OMINECA MULTILEVEL CARE FACILITY

Capital Project Business Case

Submitted to the Ministry of Health and Ministry Responsible for Seniors

March 1, 2001

Submitted by:

Northern Interior Regional Health Board

Prepared with the assistance of:

Health Services Group

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EXECUTIVE SUMMARY

Omineca Lodge was built in 1977 as a seniors' residence with 18 self-care suites and 36 beds for individuals requiring personal care. The building was designed for people with a considerable degree of self-sufficiency and mobility. Today 56% of residents use a walker or a wheelchair, approximately 80% suffer from some form of dementia and the overall level of care exceeds the original purpose of the building. The existing building no longer meets Adult Care Regulations, the BC Building Code 1998, or the BC Fire Code. The Northern Interior Regional Health Board (NIRHB) has determined that a new multilevel care facility is necessary to meet the residential care needs of seniors, to replace Omineca Lodge and to provide significant service expansion to seniors in the Omineca Integrated Health Services area.

The NIRHB objectives for this Project include:

- to provide an appropriate and safe environment for the delivery of care to the current residents of Omineca Lodge;
- to support the development of a range of services for seniors which promote integration of services, a seamless continuum of care and improvements in the delivery of care.

The NIRHB proposes a project that includes three components:

1. Building a new 50 - bed multilevel care facility on the site of St. John Hospital in Vanderhoof to accommodate the 36 current continuing care residents of the Omineca Lodge and six residents currently occupying temporary extended care beds at St. John Hospital;
2. Opening a new Adult Day Centre in conjunction with the multilevel care facility to provide five spaces, three days a week;
3. Converting the existing Omineca Lodge to seniors' supportive housing and/or assisted - living, operating on a self-sustaining basis, possibly in partnership with the private sector. Ministry funding for this phase is not required.

In addition to the residential component, several new and innovative programs are planned for incorporation into the new facility including "swing beds" (palliative, respite and/or transitional care as needed), a special dementia care unit, and visiting services including podiatry and occupational therapy. These programs will be available both for the residents of the facility and seniors living

in the community. Programs and services for these groups will be aimed at health and wellness promotion, prevention and maintenance of functional abilities. The eventual conversion of the existing Omineca Lodge into supportive housing and/or assisted living units will complete the continuum of care and services as envisioned under the Ministry of Health Continuing Care Renewal Strategy.

The following table summarizes the first two components of this project, including estimated time frame, capital and operating costs. The assisted-living project is not requesting funding and planning has not advanced to a sufficient state to allow the determination of an estimated move-in date.

Summary of Project Components

Project Component	Move In Date	Total Project Cost	Pre - Construction Operating Estimate
Multilevel Care Facility, including Adult Day Centre	February 2003	$6,707,768	$2,803,267
Regional Hospital District Contribution		($1,000,000)	
Existing Operational Funding (Ministry and Resident contribution)			($1,612,000)
Additional Resident Contributions			($130,797)
Ministry Funding Required		$5,707,768	$1,060,470

The NIRHB is requesting capital and operating funds from the Ministry of Health for the Multilevel Care Facility and Adult Day Centre. Funds from non-governmental sources will be identified to cover the capital costs for development of the remaining components. Operating costs for the assisted - living units will be provided by the NIRHB (for health services) and market rent paid by the tenants.

Relationship to Strategic Initiatives

This project is aligned with the strategic initiatives of the Ministry of Health, the Northern Interior Regional Health Board and the Stuart-Nechako Regional Hospital District.

- The replacement of Omineca Lodge with a multilevel care facility is the **NUMBER ONE** major capital priority for the Northern Interior Regional Health Board and the only project being submitted in the >$1.5 million category.

- The renovation of Omineca Lodge for seniors housing is consistent with the NIRHB's vision of integrated health services spanning the full continuum of care.

- The project provides a more effective health service through integration and the development of a continuum of services for seniors. It demonstrates the efficient use of resources by combining several services and co-locating on an existing acute care hospital site, thus enabling services to be shared and the achievement of economies of scale.

- The proposed new facility will be located on the site of an acute care hospital allowing the two facilities to share services when needed. Co-location will also reduce the pressure and stress on residents when they do need to be admitted for an acute care episode and will help reduce the number of hospital ALC days by acting as a diversion for these clients.

The location of the facility on the hospital site will create an innovative "campus of care" that is not often seen in rural and northern communities such as Vanderhoof. The conversion of the existing Omineca Lodge into supportive housing and/or assisted living units will complete the continuum of care and services as envisioned under the Ministry of Health Continuing Care Renewal Strategy.

This project may well serve as a "pilot" for other similar projects in British Columbia.

1.0 INTRODUCTION

Omineca Lodge was built in 1977 as a seniors' residence with 18 self-care suites and 36 beds for individuals requiring personal care. The building was designed for people with a considerable degree of self-sufficiency and mobility. Today 56% of residents use a walker or a wheelchair, 72% suffer from some form of dementia and the overall level of care exceeds the original purpose of the building. The existing building no longer meets Adult Care Regulations, the BC Building Code 1998, or the BC Fire Code. The Northern Interior Regional Health Board (NIRHB) has determined that a new multilevel care facility is necessary to meet the residential care needs of seniors, to replace Omineca Lodge and to provide significant service expansion to seniors in the Omineca Integrated Health Services area. This area includes the communities of Vanderhoof, Fort St. James, Fraser Lake, Fort Fraser and their surroundings.

1.1 Background

A brief history of the initiatives that have been taken to bring this project to its current state:

- In 1983, the need for dedicated extended care beds in Vanderhoof was identified;
- In 1993, assessment of the demand for extended care beds suggested that 15 new beds were needed immediately and that 15 more would be needed in the near term. However, when the Ministry of Health, Facilities Planning and Construction Division suggested that a facility of less than 60 beds was not likely to be cost efficient, all activity on the initiative ceased.
- In 1999, a Capital Project Request was submitted to the Ministry of Health in support of a project to replace and expand Omineca Lodge, however major capital project money was only available for maintenance projects and funding was not obtained for the project.
- In April, 2000, the mayors of Vanderhoof and Fort St. James, a representative from the Regional District representing Fraser Lake and the CEO of the NIRHB met with the Minister of Health to brief him about the need for this project and the high level of community support for the plans.
- In June, 2000, a Capital Project Request was submitted for the project to the Ministry of Health. The request addressed the requirements of Part A – Needs Justification of the Health Capital Plan Requirements, 2000/2001.

- The release of the Continuing Care Renewal Plan changed the process for capital project submissions for projects of this type. The submission was rewritten and again submitted February 9th, 2001.
- Upon review of the February 9th, 2001 submission, the Ministry of Health asked the NIRHB to proceed with completion of the Business Case to support the Capital Project Request.

This Business Case includes information that expands upon the Capital Project Request previously submitted and provides the supporting documentation requested by the Ministry of Health and the Ministry of Finance and Corporate Relations.[1] This document was prepared to satisfy both Part A and Part B of the Capital Project Requirements. It is based on the direction provided in two documents:

- Health Authority Capital Plan Requirements (Ministry of Health, 2000);
- Residential Facilities Plan (Ministry of Health, January, 2001).

1.2 Project Objectives and Scope

The NIRHB objectives for this Project include:

- to provide an appropriate and safe environment for the delivery of care to the current residents of Omineca Lodge;
- to support the development of a range of services for seniors which promote integration of services, a seamless continuum of care and improvements in the delivery of care.

The NIRHB proposes a project that includes three components:

1. Building a new 50 - bed multilevel care facility on the site of St. John Hospital in Vanderhoof to accommodate the 36 current continuing care residents of the Omineca Lodge and six residents currently occupying temporary extended care beds at St. John Hospital;
2. Opening a new Adult Day Centre in conjunction with the multilevel care facility to provide five spaces, three days a week;
3. Converting the existing Omineca Lodge to seniors' supportive housing and/or assisted - living, operating on a self-sustaining basis, possibly in partnership with the private sector. Funding for this phase is not required.

In addition to the basic services offered in any multilevel care facility, several new and innovative programs are planned for incorporation into this specific development. They include "swing beds" (palliative, respite and/or transitional

[1] Ministry of Finance and Corporate Relations. Capital Project Business Case. Undated.

care as needed), a special dementia care unit, and visiting services such as podiatry and occupational therapy. These programs will be available both to residents of the facility and seniors living in the community. Programs and services for these groups will be aimed at health and wellness promotion, prevention and maintenance of functional abilities.

The location of the proposed new services on the St. John Hospital site will assist in the creation of a "campus of care" where services can be shared and patients redirected from acute care to the new facilities as appropriate. Moreover, the conversion and renovation of the existing Omineca Lodge into supportive housing and/or assisted - living units will complete the continuum of care and services as outlined in the Ministry of Health Continuing Care Renewal Strategy.

1.3 Summary of the Project

The following table summarizes the main components of this project, including estimated time frame, capital and operating costs

Exhibit 1

Summary of Project Components

Project Component	Move In Date	Total Project Capital Cost	Pre – Construction Operating Estimate
Multilevel Care Facility, including Adult Day Centre	February 2003	$6,707,768	$2,803,267
Assisted – Living	TBD	TBD	$922,000

The NIRHB is requesting capital and operating funds from the Ministry of Health for the Multilevel Care Facility and Adult Day Centre. The Regional Hospital District will be contributing $1,000,000 towards the capital construction costs.

Funds from non-governmental sources will be identified to cover the capital costs for development of the remaining components. Operating costs for the assisted - living units will be provided by the NIRHB (for health services) and market rent paid by the tenants.

1.4 Document Organization

The material included in this document addresses the requirements for Capital Project Funding required by the Ministry of Finance and Corporate Relations. In addition, the Ministry of Health requirements for capital plans and continuing care renewal plans were considered in preparing this document. The organization of the Business Case is shown in the following table.

1.0 Introduction	This section describes the objectives, scope and history of the project. It also includes a summary of the time frame, estimated capital and pre – construction operating costs for all components of the project.
2.0 Needs Justification	The need for the project is addressed from the perspective of consistency with the strategic direction of the Ministry of Health and NIRHB and population health need.
3.0 Multilevel Care Facility	The multilevel care facility and adult day centre are described in terms of the services to be offered, projected workload, proposed staffing and space requirements.
4.0 Assisted – Living	The proposed assisted - living units are briefly described.
5.0 Project Specifics	This section provides more detailed information about the project, including use and development of the identified site, evaluation of the existing Lodge, physical and operational relationships, conceptual development schemes and resources required to support the project.
6.0 Implementation Plan	This section outlines the proposed approach to the project and provides an overview of the work plan and timelines for the project.
7.0 Conclusion	This section summarizes the information presented.
Appendices	The appendices provide additional information supporting the Business Case.

2.0 NEEDS JUSTIFICATION

This section provides information to support the demand for this project.

2.1 Existing Building Deficiencies

In 1999, a report was prepared by Access Engineering Consultants and RBB Architects in response to a request by the NIRHB for an assessment of Omineca Lodge's compliance with the Building Code and the Adult Care Regulations.

The following is a quote taken directly from the Discussion and Recommendations section of this report (pp.25-26):

> *"The building, as designed and constructed in 1977, appears to have met the BC Building Code 1975 requirements. As designed, the building for the most part, met the needs of the residents. Many of the issues facing staff would have been similar to the issues in 1977 and working conditions are less than ideal.*
>
> *The changes and maintenance work to the building have disrupted the integrity of the fire separations and these require restoration.*
>
> *Over time, with the ageing of the resident population, the change in use to a higher level of care facility, the physical limitations and layout of the facility impeded the care of the staff and affect the quality of life for both residents and staff. Some of these deficiencies are qualitative; others are quantitative and are in conflict with the requirements of the BC Building Code and the Adult Care Regulations.*
>
> *It would not be possible to correct all the deficiencies (e.g. the location of beds on two levels), so even if the facility were renovated to correct as many deficiencies as possible, the facility would not be 100% successful as an Intermediate Care Facility.*
>
> *The most significant deficiency, from a Building Code point of view, is that the building is a wood frame combustible building, and is required to be non-combustible. This requirement for non-combustibility was initiated by the change of use and the addition of the pitched roof that destroyed the separations provided by the firewall. The BC Building Code 1985, which would have been in effect at the time of the changes, had the requirement for non-combustibility, and the requirement is still applicable under the current code.*
>
> *As discussed earlier, the correction of this problem can be achieved through restoring the firewall and upgrading the fire resistance ratings in the self-care west wing. The extent of the renovations would be very disruptive to the continuing use of the facility.*

Given the extent of the renovations required, the cost of the work, the level of disruption and the fact at the end of the renovations the facility would still not be fully successful as an Intermediate Care Facility, we recommend that it is not cost effective or productive to pursue that option.

Based on the findings of our report and our experience as Architects and Engineers, we make the following recommendations:

1. *The Lodge revert to its original residential use.*
2. *Double occupancy bedrooms be converted to large single occupancy bedrooms.*
3. *Study ways to provide larger washrooms. This could perhaps be achieved by demolishing existing walls between two washrooms and making one large shared washroom.*
4. *The Omineca Lodge building be renovated to the extent required to restore the required fire separations, and correct the items of non-compliance that relate to exiting, fire separations, and resident health and safety. Any other items that can reasonably be addressed should be included in the scope of work.*
5. *A new one-story facility be constructed as an Intermediate Care Facility, which fully complies with all of the requirements of the BC Building Code 1998, and the Adult Care Regulations for the best possible quality of life and safety for the residents and staff."*

See Appendix A for a copy of the full report.

The Fire Chief of the Vanderhoof Fire Department has also documented concerns including non-compliance of the BC Fire Code. See Appendix A for the full text of the Fire Chief's letter.

The letter found in Appendix A lists the concerns of Community Care Facility Licensing including multiple areas of non-compliance with the Community Care Facility Act.

Finally, Appendix A also contains a presentation made in 1998 by Omineca Lodge staff to the Nechako Valley Community Health Advisory Committee providing an overview of some of the inadequacies of the Lodge from a staff perspective in providing care to the type of clients who reside there.

2.2 Consistent With Strategic Directions

This section presents support for this project based on the fit with the strategic initiatives of the Ministry of Health, the Northern Interior Regional Health Board and the Stuart-Nechako Regional Hospital District.

2.2.1 Ministry of Health Goals

The completion of this project will allow the NIRHB to more effectively meet the strategic goals as identified by the Ministry of Health, specifically:

- access to health care services within an acceptable time period (goal 2)
- access to health care services within specified geographic distances (goal 3)
- adequate supply of health care services (goal 4)
- high quality health services that improve health and health outcomes, and satisfy British Columbians' expectations (goal 6)

2.2.2 The Northern Interior Regional Health Board Goals

The replacement of Omineca Lodge with a multilevel care facility is the **NUMBER ONE** major capital priority for the Northern Interior Regional Health Board and the only project being submitted in the >$1.5 million category.

The renovation of Omineca Lodge for seniors housing is consistent with the NIRHB's vision of integrated health services spanning the full continuum of care and is consistent with the Ministry of Health's position as expressed by David Babiuk, Associate Deputy Minister of Health, at the May 2000 'Future in Capital Planning' conference.

In a recently completed Health Services Plan, the NIRHB described their mission as, "improving the health of residents of the Region; promoting wellness, self-responsibility and the prevention of illness, and the demonstration of efficient use of resources".[2] The proposed project provides a more effective health service through integration and the development of a continuum of services for seniors. It demonstrates the efficient use of resources by combining several services and co-locating on an existing acute care hospital site, thus enabling services to be shared and the achievement of economies of scale.

The project is supported by the Stuart-Nechako Regional Hospital District.

[2] NIRHB Health Services Plan, April 1, 2000 – March 31, 2003.

2.2.3 Continuing Care Renewal

Continuing Care Renewal is intended to both increase service capacity and redesign the existing system of care in order to improve access to, and choice within, an enhanced range of community support options for continuing care clients[3]. The Ministry of Health has developed Continuing Care Renewal as a strategic provincial initiative including the goal to decrease residential care utilization and alleviate pressures on hospitals.

There are a number of priorities for action identified in the final report of the review, which apply to this project.

Exhibit 2

Ministry of Health
Priorities For Action – Continuing Care Review

Number	Priority For Action
1.4	Ensure operating funding is sufficient to enhance community capacity, promote quality and support new and innovative service delivery models.
1.5	Ensure capital funding is sufficient to maintain, and upgrade, residential facilities and adult day centres.
2.4	Ensure each community has a range of flexible housing options, including supportive housing.
3.4	Foster local innovation in service delivery.

The proposed new facility will be located on the site of an acute care hospital. This close proximity will allow the two facilities to share services when needed, will reduce the pressure and stress on residents when they do need to be admitted for an acute care episode, and will attempt to reduce the number of ALC days at the hospital by acting as a diversion for these clients. The new facility adjoining St. John Hospital will benefit from the infrastructure at the hospital including such services as diagnostic services, medical, clinical and administrative support, food services and other support services. In addition, the location of the facility on the hospital site will create an innovative "campus of care" that is not often seen in rural and northern communities such as Vanderhoof. This project may well serve as a "pilot" for other similar projects in British Columbia.

Continuing Care Renewal service redesign also focuses on "designing services that prevent inappropriate emergency visits or admissions to acute care hospitals, and that support early discharge from hospital". As the Nechako

[3] Strategic Directions for Continuing Care Renewal, December 5th, 2000.

area's alternate level of care (ALC) days are higher that the provincial average (93 days per 1,000 population compared to 66 days per 1,000 population for the province), creating additional spaces for clients within the new facility should have a marked impact on ALC days, thereby reducing overall acute care costs.

One of the facets of service redesign outlined in the Continuing Care Renewal plan is to "encourage the development of enhanced options for supportive living". This project creates the potential to renovate the existing Omineca Lodge building creating additional supportive housing units for the community. This building will be completely self-sufficient and creates opportunities for partnership with the private sector.

2.3 Demographics / Population Need

Omineca Lodge is located in Vanderhoof, which is part of the Nechako Local Health Area (56). Along with Nechako, there are two other LHAs included within the Northern Interior Regional Health Board - Burns Lake and Prince George.

2.3.1 Changes in Population Distribution

Changes in population distribution, especially in the older age groups, will have a marked impact on continuing care service usage. The demographic information provided in this section was extracted from PURRFECT 5.0 & PEOPLE 24 available through the Ministry of Health.[4]

Exhibit 3 indicates that the 75+ age cohort is growing in all NIRHB LHAs.

Exhibit 3

Northern Interior Regional Health Board
Population 75+

	Population 2000	Population 2020	% Change 2000 to 2020
Prince George	2,354	5,917	+ 151%
Nechako	488	1,186	+ 143%
Burns Lake	286	636	+ 122%

While the NIRHB and Nechako remain below the provincial rate of per cent of population greater than 75 years of age, Exhibit 4 indicates that the growth in the

[4] Although PEOPLE 25 population data was available at the time of writing, corresponding utilization data for 1999/2000 was not. In order to maintain consistency in data, it was determined that PURRFECT 5.0 and PEOPLE 24 would be used.

NIRHB and Nechako is significantly greater than for the Province as a whole. A complete population profile for both the NIRHB and LHA56-Nechako can be found in Appendix B.

Exhibit 4

Northern Interior Regional Health Board
Projected growth in Population 75+

	% pop > 75 1996	% pop > 75 2020	% Change 1996 to 2020
Nechako	2.0	4.7	+ 135%
NIRHB	2.2	5.3	+ 130%
Province	4.8	7.1	+ 48%

Exhibit 5 indicates that, within Nechako, the +85 age cohort is the fastest growing segment of the population posting a 208% projected increase. This group is the one most likely to require care within a residential facility.

Exhibit 5

Northern Interior Regional Health Board
Population 85+

Age Cohort	Population 2000	Population 2020	% Change 2000 to 2020
85 +	120	370	+ 208%
80 to 84 years	133	328	+ 147%
75 to 79 years	235	477	+ 103%
75 +	488	1186	+ 143%
0 to 74 years	18,235	20,012	+ 15%

Provincially, the +75 age cohort will grow by 62%. Therefore the NIRHB and its sub-regions have a seniors' population growing at a rate 2.0 to 2.4 times that of the province.

The following table from Statistics Canada and produced by BC STATS, demonstrates the percentage of persons living alone within the NIRHB generally, and within Omineca specifically, is similar to the provincial rate. Again, those living alone are more likely to require care in a residential facility than those living with a spouse or other family members.

Exhibit 6

Northern Interior Regional Health Board
Percent of People Living Alone

1996 Census Data	Total persons age 65+	Living Alone	% Living Alone
Omineca	1175	315	26.8%
Health Region 15	7120	1980	27.8%
Province	448,205	127,965	28.6%

2.4 Utilization Patterns

This section provides information about Alternate Levels of Care (ALC)utilization to support the need for the multilevel care facility.

ALC days and cases provide an indication of unmet need for facility care. Reducing ALC days is a focus of Continuing Care Renewal and therefore it is important to examine these rates. Nechako's ALC cases / per 1000 population is slightly below the provincial rate while days / per 1000 population is higher than the provincial rate. The Nechako/NIRHB rates are consistent with the experience of other northern health authorities. Additional residential care facility beds will allow people to be placed appropriately and should have a marked impact on ALC days and their associated costs. Exhibit 7 outlines the relevant rates.

Exhibit 7

Northern Interior Regional Health Board
Alternate Levels of Care

1998/99	Cases / 1000 Population	Days / 1000 Population
Nechako	2.33	93
NIRHB	2.89	131
Province	2.58	66

2.5 Current Residential Beds

The current distribution of residential beds in NIRHB and Nechako is shown in the Exhibit 8.

Exhibit 8

Northern Interior Regional Health Board
Current Residential Beds

Level of Care	NIRHB	Nechako
EC	146	6
IC3	112	15
IC2	113	20
IC1	5	0
PC	0	0
Respite	5	1
Total	377	42

2.5.1 Characteristics of Omineca Lodge Residents

In general, the majority of residents currently at Omineca come from the surrounding community. On occasion, when there are no beds available, seniors have had to transfer out of the area. Continuing Care Renewal has a goal of "encouraging greater emphasis on independence, personal choice and consumer participation". Thus, if a senior requires facility care, he/she should ideally be able to access this care in his/her home community.

Currently, 40% of Omineca residents are at the IC2 level, 54% are at the IC3 level, and 6% are classified as Extended Care[5]. Often, EC residents with dementia and significant behavioural problems cannot be accommodated within the existing facility and must be moved to special care units in Prince George or other areas of the province.

Any care level above IC1 is inappropriate for the current facility as it was designed and built as a senior's residence only.

From 1994 through 2000 care levels have been rising overall, mostly through the decline in the number of residents within the IC1 category. Only 3 IC1 clients remain within the region.

[5] Information from Omineca Lodge, Director of Care, February 5, 2001.

The length of stay (LOS) for Omineca residents is presented below in Exhibit 9.

Exhibit 9

Omineca Lodge
Length of Stay

Care Level	Mean LoS months	Median LoS months	Range months
IC2	26	13.5	1 to 93
IC3	37	14	0.5 to 162
EC	37	45	17 to 49
All Residents	32	14.5	0.5 to 162

As Omineca Lodge was originally built to provide service to personal care clients there are still many of the original residents in the facility ageing in place. This skews the average length of stay to a high figure of 32 months. The median length of stay, however, is much lower at 14.5 months.

The age profile of Omineca Lodge residents is shown in the exhibit.

Exhibit 10

Omineca Lodge
Age Profile

Care Level	Age (Mean)	Age (Median)	Age Range
IC2	80	81	62 to 88
IC3	81	82	53 to 97
EC	80	80	72 to 88
All Residents	81	81	53 to 97

2.5.2 Wait List For Facility Placement

Wait lists for the Region as a whole have shown a steady increase over the last 16 months with a significant and consistent increase from September 1999 to present. There are presently 86 individuals waitlisted for residential care.

The waitlists for Omineca Lodge and St. John Hospital are variable and seasonal. The combined waitlist has averaged 8 clients over the last sixteen months (4 at present). With an additional assessor now based in Vanderhoof it is expected that these numbers will grow as a backlog of requests is addressed

and case finding proceeds. There are also assessors in Fort St. James and Fraser Lake.

The current waiting time from time of assessment to time of admission to Omineca Lodge, as at January 2001, is approximately 2-3 months.

Overall, it is evident that the current and anticipated future utilization patterns support the need for a new residential care facility to replace the outdated and inappropriate Omineca Lodge. In addition, there may well be clients from other communities awaiting placement in Omineca Lodge.

2.6 Continuing Care Services

Currently, in the Nechako area, there are several programs and services available in continuing care including long term care case management, home nursing, respite (1 bed in Omineca Lodge and in-home respite), home support, LTC facility beds, and community rehabilitation (OT/PT). These programs are offered to clients in the Omineca Integrated Health Services Area. Exhibit 11 below presents the age standardized utilization rate of the various continuing care services in the Nechako area as compared to the BC utilization rate.

Exhibit 11

Northern Interior Regional Health Board
Utilization of Continuing Care Services

	Nechako Total Clients/1000 pop'n	Nechako total raw count	98/99 ASUR per 1,000	BC rate	Nechako relative to BC rate
RESIDENTIAL CARE					
Extended Care Days	1	2,731	336	943	36%
IC1 Days	0.12	32	3.9	55	7%
IC2 Days	3.89	7,125	963	602	160%
IC3 Days	2.95	5,227	668	652	102%
Personal Care Days	0	0	0	5.2	0%
DIRECT & COMMUNITY CARE					
Home care Nursing Cases	5.44	66	5.5	10.1	54%
Home care Nursing Visits		2,144	193	187.9	103%
OT cases	1.07	13	1.26	2.8	45%
OT Visits		43	3.89	8.52	46%
PT cases	0.41	4	0.41	3.65	11%
PT visits		10	1.01	17.19	6%
Adult Day Care Cases	0.36	3	0.36	1.4	26%
Adult Day Care Visits		49	5.79	48.8	12%
Home Support Cases	14.15	133	14.5	11.7	124%
Home Support Hours		17,148	1820	1940	94%

Nechako LHA has a higher utilization rate of IC2 days than the provincial average, but a significantly lower utilization of Extended Care Days. This high utilization of IC2 days can be explained, in part, by the fact that these may be some of the original residents of the seniors independent living or personal care suites at Omineca Lodge. Given the resources of the community, and the commitment of the region under the Continuing Care Renewal Program, to provide services to seniors so that they can remain in their own homes longer, the rates of utilization for IC2 days are expected to drop dramatically.

However, given the increasing age of the population, and the increase in the absolute numbers of people in the older age groups, it is anticipated that EC utilization rates will increase. Thus, the provision of care for these people in the safe and secure environment of a new multilevel care facility is required. Currently, many Extended Care level patients are transferred to other facilities in Prince George or other areas of British Columbia, due to the inability of the

current structure to safely meet the needs of these residents. See Exhibit 12 for a graphical representation of residential care bed days data.

Exhibit 12

Northern Interior Regional Health Board
Residential Care Bed Days/1000 Population Compared to BC Average Rates, 1998/99

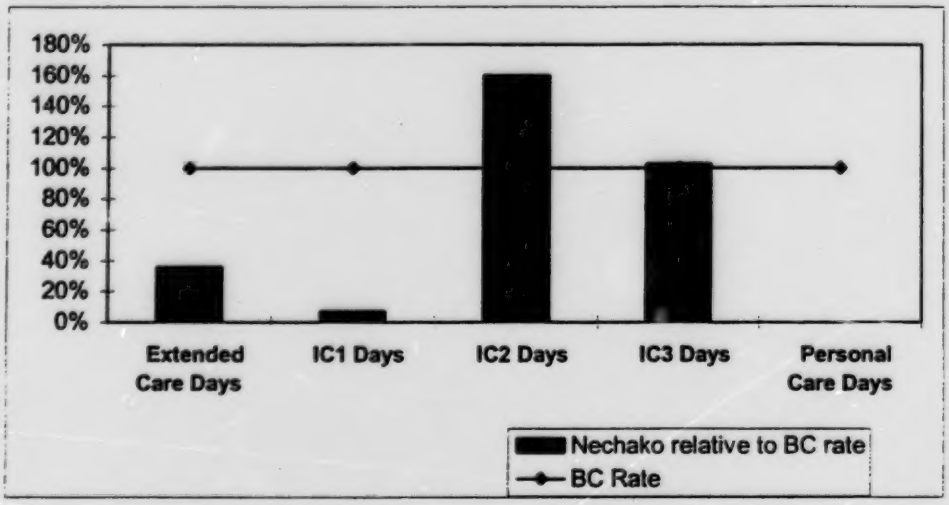


Exhibit 13 illustrates that for Intermediate Care 2/3 and Extended Care, while the NIRHB as a whole is slightly above provincial rates, Nechako is below provincial rates – one of the lowest in the north.

Exhibit 13

Northern Interior Regional Health Board
Cases/1000 Population Compared to BC Average Rates, 1998/99

1998/99	Cases / 1000 Population	Days / 1000 Population
Nechako	9	1925
NIRHB	12	2562
Province	11	2199

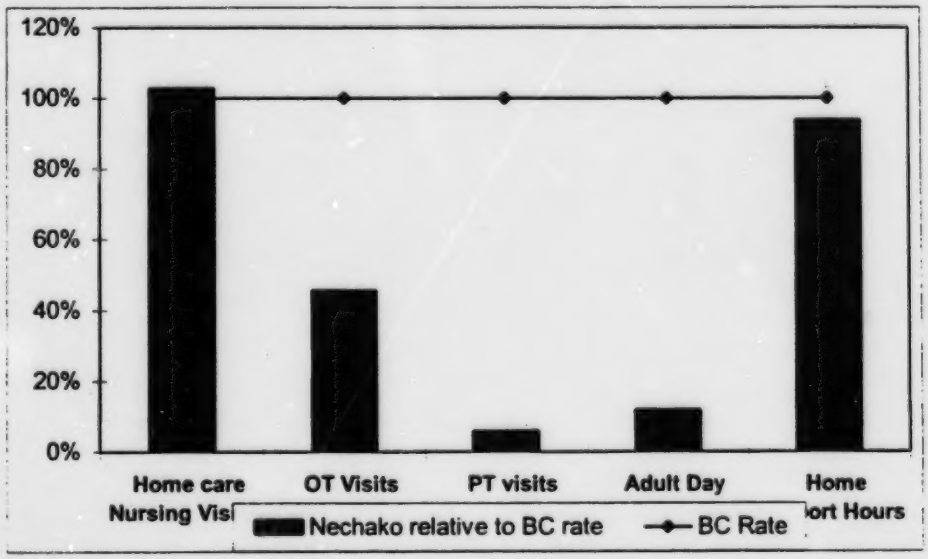
The needs of the Omineca sub-region tend to be masked and underrepresented as it is located between the sub-regions of Prince George and Burns Lake, both of which have utilization rates higher than the provincial average.

2.7 Associated Program Utilization

The continuing care service utilization in the Nechako area as compared to the British Columbia utilization rates is shown in Exhibit 14. Although home nursing visits and home support hours are close to the provincial rate, adult day care cases, occupational therapy, and physiotherapy are significantly below. These services are ones that if available, tend to increase the ability of seniors to remain in their own homes or in supportive housing longer, thus deferring or avoiding unnecessary institutionalisation.

Exhibit 14

Continuing Care Service Utilization Rates for Nechako compared to BC Rates, 1998/99



The rural nature of the communities in the Nechako area entails extensive travel time for staff supporting clients in their own homes. Home Nursing does not, and Home Support finds it difficult to, cover the needs of isolated and confined clients who require increasing hours of care and who would do better in a residential program which supports ageing in place. Therefore, these services may not be able to replace residential care and should be considered to augment this service.

2.8 Notional Bed Allocation - NIRHB

The notional bed allocation for NIRHB calculated by the Ministry of Health is for 13 new beds after substitution. The Board endorses the allocation of eight new beds to Nechako through this project.

2.9 Projected Utilization of Continuing Care Services

Projections have been developed for continuing care services using two approaches - a straight-line projection based on current utilization and a substitutionary approach suggested as part of the Continuing Care Renewal initiative.

2.9.1 Straight-line Projections

The projected utilization (in number of clients) of continuing care services in the Nechako area from 2001 to 2015 is shown in exhibit 15. These projections are estimates only and are based on maintaining straight - line utilization.

Exhibit 15

Projected Utilization for Continuing Care Services in Nechako (2001 – 2015)[6]

	Nechako Total Clients/1000 pop'n 1998/99	2001 Utilization (# of clients)	2005 Utilization (# of clients)	2010 Utilization (# of clients)	2015 Utilization (# of clients)
POPULATION (based on PEOPLE 24)		18,944	19,845	20,628	21,445
RESIDENTIAL CARE					
Extended Care Clients	1	19	20	21	21
IC1 Clients	0.12	2	2	2	3
IC2 Clients	3.89	74	77	80	83
IC3 Clients	2.95	56	59	61	63
Personal Care Clients	0	0	0	0	0
DIRECT & COMMUNITY CARE					
Home care Nursing Cases	5.44	103	108	112	117
Home care Nursing Visits					
OT cases	1.07	20	21	22	23
OT Visits					
PT cases	0.41	8	8	8	9
PT visits					
Adult Day Care Cases	0.36	7	7	7	8
Adult Day Care Visits					
Home Support Cases	14.15	268	281	292	303
Home Support Hours					

[6] Population projections based on PEOPLE 24. Assumes straight-line projections of utilization. Use all population, not just those 65+ or continuing care eligible.

In residential care, Extended Care cases could increase to 20 in 2005. It is unlikely that much substitution of services could occur for this group as they are usually residents with complex medical problems, or with dementia and related behavioural problems. These residents will be housed within the special care unit of the new multilevel care facility.

As the focus of Continuing Care Renewal is on providing residential care for those residents with the most intense care needs, it is assumed that IC I and IC 2 residents will not be admitted to care facilities in the future. Instead, they will be cared for in the community with such programs as supportive housing, assisted - living, home care services, adult day care, respite care, etc.

Assuming straight - line utilization, there will be 59 people at the IC 3 level in 2005. A proportion of this group will be cared for in an assisted - living type setting if it is available in the community.

2.9.2 Continuing Care Substitution Model

Under Continuing Care Renewal, the intention is to shift the distribution of services so individuals receive care in the community as much as is possible. This direction suggests enhanced community supports with the use of facility care for individuals who have more complex care needs. The current distribution of continuing care services is shown in the following table.

Exhibit 16

Continuing Care Services
Current Distribution of Service Delivery, 1999/2000

Care Level	Clients				Percent		
	Residential Care[7]	Home Support	Assisted Living	Total	Residential Care	Home Support	Assisted - living
EC	8	11		19	42.1%	57.9%	0%
IC 3	14	10		24	58.3%	41.7%	0%
IC 2	19	47		66	28.8%	71.2%	0%
IC 1		60		60	0%	100%	0%
PC		18		18	0%	100%	0%
Total	41	146		187	21.9%	78.1%	0%

[7] Does not include one respite bed at Omineca Lodge.

Continuing Care Renewal is predicated on the strategy that facility care will only be provided for individuals with the most intense care needs, individuals at EC and IC 3 levels. It is assumed that IC 1 and IC 2 residents will not be admitted to care facilities in the future, but rather, will be supported to live in the community with programs such as home care services, adult day care, respite care, etc. These individuals will also likely occupy assisted - living units.

Using the projected service utilization rates for residential care and home support shown in Exhibit 17 and a straight-line population expansion, the re-distribution of services has been calculated using a preliminary application of the medium shift scenario. In addition to residential care and home support, there has been a shift to identify the potential demand for assisted - living.

Exhibit 17

Proposed Continuing Care Service Distribution 2005
Based on Total Projected Demand using 1998/99 Utilization Rates and the Medium Shift Model

Care Level	Projected Number of Clients				Percent Shift		
	Residential Care	Home Support	Assisted - living	Total	Residential Care	Home Support	Assisted - living
EC	36	4	2	42	85%	10%	5%
IC 3	40	24	16	79	50%	30%	20%
IC 2	0	114	61	175	0%	65%	35%
IC 1	0	143		143	0	100%	0
Total	**76**	**285**	**79**	**439**	**17.1%**	**64.8%**	**18%**

Exhibit 17 outlines the service demand based on the medium shift model. The assumptions inherent in the medium shift model are accepted as reasonable for planning purposes. As part of the development of the Continuing Care Plan for the NIRHB there will be further analysis regarding the appropriateness of the shift for this community. As well, the next stage of planning will examine these projects more fully as the service models are defined.

3.0 THE MULTILEVEL CARE FACILITY

3.1 Residents

Upon completion of the new multilevel care facility the 36 residents of Omineca Lodge and the 6 extended care patients at St. John Hospital will be relocated. Those persons on the waitlists for both facilities will also take up residence resulting in 100% occupancy at start-up.

During the planning and construction phase for the new facility, work will be completed on the planning for renovations to the existing Lodge. At this point , the plans for the existing building include renovation of the continuing care portion of the building for use as seniors' apartments. Upon completion the 18 residents presently in seniors' apartments would be relocated to the newly renovated apartments. The current seniors apartments in Omineca Lodge would then be renovated. There is a possibility of converting some of the units into assisted - living space and this will be examined in further detail as the planning process continues.

3.2 Description of Services

A variety of services will be available to both residents and Adult Day Care Centre attendees. These services will focus on health and wellness promotion, disease prevention, and maintenance of functional and social capabilities. The following provides an overview of some of the services to be provided.

- Activity therapists will provide suitable professional direction in assisting residents to maintain their maximum physical and mental functions as long as possible.
- Visiting professional services (e.g. medical, dental) will be an integral component of the care planning for each resident.
- Consultation and treatment by the appropriate health care practitioner will be arranged for the residents, e.g. podiatry, mental health, speech pathology, audiology, and social work.
- Occupational Therapy and Physiotherapy will assist the residents to maintain their functional ability.

In addition to the services provided within the facility, there will also be close linkages with community-based services. These linkages will act as referral

sources and will include families, physicians, other agencies and professionals, and long term care case managers. Services outside of the Omineca Integrated Health Service area which will be available to residents of the multilevel care facility include the following.

- The Geriatric & Assessment and Treatment Unit (GATU) in Prince George will be a referral source for these residents to assess and modify behaviour and treatment in order to enable their return to the MLC facility. This service will keep residents closer to their home rather than referral to St. Vincent's or Riverview (881 km by road from Vanderhoof to Vancouver).
- The Regional Outreach Services of the Geriatric Assessment program will have the ability to provide assessments on site. Specialist consultation to the doctors & staff of the Omineca IHS Region will be ongoing. There is a valuable element of medical and nursing staff education that is provided when the teams of specialists come to the area.

In summary, the facility will offer a range of continuing care services to a range of clients from Vanderhoof and surrounding areas. Together with the availability of seniors supportive housing and assisted - living on the current Omineca Lodge site, an entire "continuum of care" will be available for residents of the Omineca Integrated Health Services area.

3.3 Specific Service Areas

Some of the unique features to be incorporated into the new facility are described in this section. These features are aimed at enhancing the ability for seniors to continue living independently, and at promoting health, wellness, and maximum functioning for persons residing in care facilities. Thus, these innovative programs are aligned with the Continuing Care Renewal Strategy.

3.3.1 Special Care Unit

The proposed 50-bed multilevel care facility will provide an opportunity for seniors to stay in the same location as their health needs change over time. If 10 beds are dedicated to Special Care such as Alzheimer's and other forms of dementia, residents will not have to leave their community for this type of care. Currently, approximately 80% of the residents at Omineca Lodge suffer from

some degree of dementia. When their care needs increase and they require care in the safe and secure environment of a special care unit, these residents must leave the community for Prince George or other areas with available beds. This move is disrupting to the client and family. Given the increasing numbers of elderly people, particularly in the oldest age groups where the prevalence of dementia is approximately 34%[8], planning for a special care unit is timely and appropriate.

There are several design options available for Special Care Units and these will be examined and compared during the detailed planning process. At a minimum the unit will be secure, flexible to resident needs, and homelike.

3.3.2 Swing Beds (Palliative, Respite, Transitional Care)

It is envisioned that the facility will offer several "swing beds". These beds will be used for a variety of purposes depending on the needs of the residents at the time. Fully detailed design features for the "swing bed" concept are still to be explored however a two-room unit is visualized with a room in between the two set up comfortably to accommodate family members and volunteers attending the client. The menu of services proposed for these swing beds includes:

Palliative Care – A palliative care component is envisioned which will respond in a cost-effective manner in the facility rather than in the acute care facility. A hospice program operated by volunteers has been in place in Vanderhoof since 1987 and it is planned that their services will continue in the new facility.

Respite Care – The respite component will provide short-term respite care for eligible clients to relieve the stress on caregivers. Currently, there is one respite bed available in Omineca Lodge, and there are also respite services in the community. It is planned that these "swing beds" will be available for respite care on a weekly or monthly basis. There is also a recognized need for weekend respite only, and this option will be explored further.

Transitional Care – Transitional care provides a cost effective alternative to prolonged acute care hospitalisation for patients who are no longer acutely ill but who require more recovery time before discharge home or admission to a

[8] Canadian Study of Health and Aging, 1994. 34% of those over 85 will experience Alzheimer's disease or a related dementia.

residential care facility. Transitional care units are designed to provide a cost effective, short-term alternative to prolonged stays in hospital.[9]

It is anticipated that by offering these services within the facility, there will be a decrease in inappropriate admissions to the acute care hospital. Education and awareness will be promoted to ensure physicians, other service providers, and family members are aware of the variety of services offered through the multilevel care facility.

3.3.3 Amenity Spaces

As a multilevel facility, the care design will have the flexibility to support the basic requirements of care in the future. It is anticipated that future residents will be admitted at the Intermediate Care 3 and Extended Care levels, and therefore the design must accommodate those with complex medical needs, as well as those with dementia and related behaviour problems.

A multi-purpose room will provide for larger scale resident activities including seasonal special events. The common area will enhance the realization of the residents' individual potential for activities of daily living by providing stimulation and pleasure. A variety of public and private activity spaces will be available to allow the resident maximum choice and autonomy.

Amenity spaces for such activities as hairdressing, and visiting specialists will enhance the well being of the resident. These spaces will also be available for use by Adult Day Care Centre clients. Outdoor space will be provided.

The space allocation for the project has been derived from the Multilevel Care Facility planning model provided by the Ministry. This model determines the space available for various program areas using unit rates based on size of the facility. A complete inventory of physical space will be outlined during the next planning phase of this project.

3.3.4 Adult Day Centre

In Vanderhoof and surrounding areas there are a significant number of residents who do not yet require facility care but who are causing concerns for caregivers in their homes attempting to meet 100% of care needs 7 days a week without

[9] British Columbia Ministry of Health and Ministry Responsible for Seniors. "Requirements for Continuing Care Renewal Plans: 2000/01 – 2004/05". January 12, 2001.

necessary relief. The addition of an Adult Day Care Centre in this facility will address this unmet need. The Adult Day Care Centre will have both rehabilitation and activation components to address the needs of the residents in the facility as well as the needs of community members who might benefit.

The location of the Adult Day Care Centre within the care facility is beneficial in that it provides an opportunity for seniors who may require admission in the future to become familiar with the environment and the programs offered, easing the transition in the future. As well, the location provides a synergy with the programs in the care facility and results in an economy of scale when offering the programs.

Services provided to the Adult Day Care clients will include:

- well balanced meals and snacks,
- transportation on a wheelchair accessible bus,
- recreational programs,
- bathing facilities,
- respite for caregivers,
- treatments,
- supervision of medications,
- on-going care planning in a safe and secure environment,
- information to clients and families, with referrals to appropriate community and Regional resources,
- opportunities to maintain and improve functional abilities and psychosocial health with professional supervision,
- a safe environment for the mentally fragile as the proposed facility is secure,
- space for rest if required,
- services of the visiting podiatrist,
- services of the visiting hairdresser, and
- occupational therapist assessments of functional problems and assessment for appropriate safety devices and mobility aids.

To enhance the continuum of care and services offered to seniors within the new multilevel care facility, as well as those living in the community, an Adult Day Care Centre with 5 spaces available 3 days a week, is included in the project.

3.4 Projected Workload

The projected workload for the Multilevel Care Facility and Adult Day Centre is shown in the Exhibit 18. Projected utilization, using the existing rate estimates, demonstrates that there will be seven clients who require adult day centre services in 2005.

Exhibit 18

Multilevel Care Facility and Adult Day Centre
Projected Workload

	Number
Multilevel Care Facility	
Number of Beds	50
Number of Admissions	8 per year
Maximum Resident Days	18,250
Percent Occupancy	100%
Projected Resident Days	18250
Adult Day Centre	
Number of Spaces	5
Maximum Number of Days	156
Percent Occupancy	70%
Projected Days	109

3.5 Proposed Staffing

The proposed staffing for the Care Facility and Adult Day Centre is based on the guidelines established by the Ministry of Health.

Exhibit 19

Multilevel Care Facility
Proposed Staffing Full Time Equivalents

	FTEs
Resident Care	26.85
Therapeutic/Recreation Services	2.00
Food & Nutrition	4.50
Support Services	4.60
Administration (including office support)	1.40
Total	39.35

3.6 Projected Operating Budget

The proposed operating budget for the 50 - bed multilevel care facility and Adult Day Centre is based on the following assumptions:

- the Ministry of Health contribution for each MLC bed is a maximum of $125 per day;
- the Resident portion for each MLC bed is $26.30 per day (March, 2001 rate);
- the Ministry of Health contribution for each ADC day is a maximum of $70 per day;
- the client contribution for each ADC day bed is $7.00 per day.

Exhibit 20

Multilevel Care Facility
Proposed Operating Budget

Operational Funding	
50 Beds – MOH	$2,281,250
50 Beds – Resident Portion	$ 479,975
Adult Day Centre – Ministry of Health	$ 38,220
Adult Day Centre – Client Contribution	$ 3,822
Total Operational Funding Required	**$2,803,267**
Less current Omineca Lodge MOH funding	$1,205,000
Less current Resident Contribution	$353,000
Less funding transfer from St. John Hospital	$54,000
Additional MOH Operational Funding	**$1,060,470**
Additional Resident Funding	**$130,797**
TOTAL	**$1,191,267**

3.7 Space Requirements

The MLC facility and Adult Day Centre will depend upon some services offered by St. John Hospital. These services include areas such as food and nutrition, laundry, plant operations, administration and materiel management. The Ministry of Health MLC Design Guidelines indicate a total of 3,138 m^2 will be required for 50 beds and the ADC. A summary of space requirements for major areas is shown in Exhibit 21.

Exhibit 21

Multilevel Care Facility
Summary of Space Requirements

	M^2
Residential	2,235
Administration	236
Support	322
Service	418
Food Services	204
Shared Spaces (food, plant, laundry, etc.)	(277)
Total Building Gross Area	3,138
Gross Area Per Bed	63

4.0 ASSISTED – LIVING

Assisted - living is based on a home care model, not a residential facility care model. Assisted - living is defined as:

> *"a form of housing that combines housing, personalized supportive services and care that are designed to respond to the individual needs of those requiring help in activities of daily living. Assisted - living care promotes maximum independence and choice by addressing the individual needs and preferences of each resident while encouraging the involvement of a resident's family and friends. Assisted - living is often in purpose - built buildings that are designed to afford a private, home - like atmosphere for each resident. Residents are encouraged to furnish their own (most often rented) apartments which are provided with many of the amenities of home"."*

4.1 Participants

A tenant in the assisted - living complex would be eligible for continuing care services and require both housing and care services. Most of the tenants could be described as "frail" and likely would have characteristics commonly found in a person assessed at the IC2/IC3 level of care i.e. the person who is independently mobile, requires moderate assistance with activities of daily living and daily supervision. Potential residents may include those who are:

- 75 and over
- living alone with inadequate supports
- experiencing a moderate disability

Seniors might choose to live in an assisted - living housing environment for several reasons:

- A convenient location, close to other health services
- Health and safety considerations
- Opportunities for company and recreation
- Reduced housekeeping and maintenance tasks, and
- Improved nutrition
- Maintain independence

They might move in as a result of an immediate need, or as a way of planning for the future when their needs might change. Although assisted - living housing has appeal for many seniors, it can be of particular benefit to those who:

- Have difficulty with tasks such as personal care, meal preparation, grocery shopping, and regular home cleaning and maintenance

- Have little social contact, causing a negative effect on mental and physical health,
- Have physical mobility problems,
- Have mild to moderate dementia,
- Have safety or security concerns, or
- Are living alone.

4.2 Description of Services

Assisted - living is another option for seniors, an alternative to moving to a residential care facility. The tenant rents the unit and tenants are free to come and go from the assisted - living facility at their own discretion.

Tenants pay monthly rent in an amount similar to what they would pay if they were admitted to a conventional continuing care facility.

The tenant would be provided with the following:

- weekly housekeeping
- one meal per day (all meals can be provided for an additional fee)
- personal emergency response system
- 24/7 on site service by assisted - living staff
- recreational/social activities
- medication assistance, if needed, through the Home Care Nursing program
- other available programs and services

If professional support services are required, they will be provided to eligible tenants through the local Continuing Care program (home care nursing, community rehabilitation, mental health programs).

4.3 Estimated Demand

Demand for assisted - living has been estimated based on two methods: using two index rates and projections estimated using a substitutionary model.

4.3.1 Index Rates

Typically, the demand for assisted - living housing is estimated using both 5% and 10% index rates. These rates are congruent with estimates of the "frail" component of the population over age 65. While it is most likely that tenants will be drawn from the 75+ age group, the index rates have been applied to the total 65+ population. We expect there will be some additional clients requiring this service from outside this age group.

The estimated demand in 2000 for assisted - living for seniors 65+ in the Nechako area using a 5% index rate equals 70 units. The number of units estimated for seniors using the 10% rate is 142. At 5%, the number of units for seniors in the 75% and over age range is 24 and 49 at the 10% rate.

Exhibit 22

Nechako LHA
Projected Demand 2000 – Assisted - living Units For Seniors Over 65

Age Group	Number	5%	10%
65 – 74	927	46	93
75 – 84	368	18	37
85+	120	6	12
All 65+	1,415	70	142

Using the same index rates, the demand for the next fifteen years has also been projected for seniors 75+. Studies show that assisted - living appeals to seniors in all age groups, but primarily to those ages 75 and over.

Exhibit 23

Nechako LHA
Projected Demand 2000, 2010, 2015 and 2015 – Assisted - living Units For Seniors Over 75

	2000	2005	2010	2015
5%	24	33	42	50
10%	49	66	83	100

4.3.2 Estimating Demand Using Substitution

Applying the principles of Continuing Care Renewal to the Nechako scenario in 2005 suggests that there will be a demand for over 79 assisted - living units. The number and care level of tenants is shown in Exhibit 24.

Exhibit 24

Estimated Demand For Assisted - Living - 2005
Based on Medium Shift

Care Level	Number of Tenants
EC	2
IC 3	16
IC 2	61
IC 1	0
Total	79

4.3.3 Current Availability of Assisted - living Units

There are currently no assisted - living units available in this area. Assisted - living will expand the range of housing options available, decreasing the number of individuals living at risk and decreasing the need for residential care services, including acute care.

4.4 Links With Other Services and Programs

Some of the tenants of the assisted - living units would likely receive Continuing Care Services such as Home Nursing Care, Case Management and Rehabilitation. They may also attend the Adult Day Centre.

Other services will be very close by to support the health and well-being of the assisted - living residents, such as physicians offices, community and social services, therapists, the multilevel care facility, the home support program and acute care services.

4.5 Projected Workload

The projected workload is shown in the following exhibit.

Exhibit 25

Nechako LHA
Assisted - living – Projected Workload

Indicator	Total
Number of Units	40
Number of Admissions	6
Maximum Number of Days	14,600
Percent Occupancy	100%
Projected Days	14,600

4.6 Projected Staffing

The staffing allocation to support the assisted - living tenants is based on the following assumptions:

- Individuals are able to look after most of their needs with minimal assistance from non-professional staff.
- Professional services are delivered within a home care model by local health authorities (case management, nursing, rehabilitation, and elderly outreach mental health services).
- Supportive services provided will include a main meal daily (with option to purchase remaining meals); weekly housekeeping, laundry and maintenance services
- 24 hour personal care assistance is available from on-site staff (activities including bathing, dressing, eating, toileting and mobilization)

The program staffing will be developed during the detailed planning phase as the client mix and service model ore more fully developed. Costs will not exceed revenue, identified below in Exhibit 26. The Board commits to operating the program within the available resources.

4.7 Proposed Operating Budget

The tenants will pay a monthly rent roughly equivalent to the amount they would pay if they resided in a care facility. The projected operating budget is shown in the following exhibit.

A number of assumptions were used to estimate the operating budget for the 60 assisted - living units:

- the Tenant portion for each unit is $400/month; and
- the Northern Interior Regional Health Board contribution for each unit is $50.00 per tenant per day.

Exhibit 26

Assisted - Living
Projected Operating Budget – 40 Units

Operating Revenue	
40 Units - Tenant Contribution	$192,000
40 Units – NIRHB Portion	$730,000
Total Operating Revenue	**$922,000**

4.8 Space Requirements

Assisted - living units are private suites, rented by tenants, who furnish their suites with their own furniture and personal belongings. Each suite is complete with private bathroom, living room, one bedroom and kitchenette. There are common areas for a central dining room or restaurant, social and activity space as well as recreational amenities. The one-bedroom units are approximately 575 square feet.

The vision for the building is single storey, built in a square, with an inner courtyard for paths, for sitting and walking. The building conforms to the housing code for seniors' independent living. The building is very residential in orientation and not at all institutional in appearance or operation. There is no nursing station but user-friendly supports will be available.

The space estimates for the assisted - living units indicate a total of 2,647 square metres will be required for 40 units.

Exhibit 27

Assisted - Living
Estimated Space Requirements – 40 Units

	Total Area m^2
Tenant Units (40)	2,172
Amenity Space	349
General Area	37
Services	89
Total	2,647

5.0 PROJECT SPECIFICS

5.1 Site Selection and Evaluation

In 1989/90 Greenwall & Bryan architects completed an analysis of potential locations for a replacement facility for the current Omineca Lodge. They identified potential sites, looked at possible options at each location and outlined the advantages and disadvantages of each of the sites. They considered three locations, including the St. John Hospital site. This site was by far the largest and all possible locations on this site were preferred over the other three alternatives considered at the time.

The next phase of the design process will exactly locate the building on the hospital grounds. Alternate locations will be examined and the most cost effective location chosen.

5.2 Land Acquisition

The preferred location is adjacent to the existing St. John Hospital on land owned by the NIRHB. Additional land acquisition is not required.

Given the current zoning of the site, the proposed facility will not require any re-zoning.

5.3 Building System Evaluation

The building systems have not been planned in detail in this phase of the project. The costs of these systems are incorporated into the MLC costing model provided by the Ministry. Further detailed work will be completed as part of the detailed design process when the appropriate consultants are brought into the process. The design will be such that operational efficiency is balanced with capital acquisition costs. Assessments of life cycle costs will be completed, where appropriate. The systems will integrate with existing systems, as required.

5.4 Accommodation Requirements

The facility will be single storey and will include space for 50 residents, with 3 double rooms and 44 single rooms. Services provided by St. John Hospital will include laundry, kitchen food preparation areas, food storage, staff canteen, waste disposal space, maintenance and generator space.

In addition, services will be provided by the acute care facility including: diagnostic services, medical, clinical and administrative support, and other support services as needed.

Further detail on the functional relationships and program space planning will be developed during the next phase of the planning process.

Multilevel Care Facility
Summary of Space Requirements

	M^2
Residential	2,235
Administration	236
Support	322
Service	418
Food Services	204
Shared Spaces (food, plant, laundry, etc.)	(277)
Total Building Gross Area	3,138
Gross Area Per Bed	63

5.5 Conceptual Development Schemes

The Multilevel Care facility and Adult Day Centre will form a residential care group within the campus of care at the St. John Hospital site. Residential care services will be centralized to minimize travelling distances for residents and staff. The residential care group comprises the following components:

High Priority Adjacency

- Multilevel Care Facility
- Adult Day Centre
- Support Services e.g. food, laundry, plant

Lower Priority Adjacency

- Diagnostic Services e.g. Imaging, Lab, etc.

A description of the Multilevel Care Facility and Adult Day Centre components is provided in the following table.

	Estimated Space Needs	Location Priorities
Multilevel Care Facility 50 bed MLC facility organized in 2 - 12 bed houses plus 2 13 - bed houses Each house to include dining and activity space for 12 to 20 people 44 single bedrooms with 3 double rooms to accommodate couples in adjoining rooms common support areas including family dining area, bathing facilities, meeting/conference, activity room, staff offices kitchen/buffet with meals and food supplies to be received from Nutrition and Food Services Hairdressing and amenity services shared with St. John Hospital	3,138	Adult Day Centre Acute Care Hospital Nutrition and Food Services, Laundry
Adult Day Centre 109 annual client attendance days capacity of 5 clients on site at one time with special programming and space for clients with dementia recreation area, crafts area 1 dining area to seat 5 clients small kitchen/buffet with meals and food supplies to be received from Nutrition and Food Services quiet room 1 office, shared staff space	200	Main Entry Multilevel Care Facility Nutrition and Food Services

5.6 Furnishings and Equipment

The estimate for furnishings and equipment for the multilevel care facility based on the MLC Design Guidelines is $500,000. A detailed list, by room and program area will be developed during the remainder of the planning process. Costs will not exceed the Ministry guidelines.

5.7 Capital Cost Estimate

Employing the Multilevel Care Budget Model used by the Ministry of Finance to develop preliminary construction cost estimates for MLC facilities, the total project cost including supplementary building & site costs for the Multilevel Care Facility and Adult Day Centre is shown in the table below.

Exhibit 28

Capital Cost Estimate

Category	Budget
Planning & Design Fees	$621,631
Construction	4,307,202
Building Supplementary Costs (Adult Day Centre)	240,000
Site Development	256,000
Site Supplementary Costs	25,000
Escalation Reserve	144,846
Construction Contingency	144,846
Project Contingency	241,410
Equipment	$500,000
Land	$0
GST	$226,833
TOTAL	**$6,707,768**

The cost per bed is $143,426 (including the Day Centre costs). Included in Appendix D is the detailed spreadsheet.

Note: This project cost estimate does not include costs associated with renovating Omineca Lodge. These funds will be raised through alternate sources. Possible partners include BC Housing through the Homes BC program, BCBC through the new partnership with the Ministry of Health, and the private sector through a public-private partnership. Ultimately Omineca Lodge will run on a self-supporting basis.

5.8 Regional Hospital District Contribution

Normally for Multilevel Care Facilities, there is no expectation of Regional Hospital District contribution towards the capital construction costs. In this particular instance however, the commitment of the citizens of the region, along with the foresight of the members of the Stuart-Nechako Regional Hospital District board, has allowed the RHD to provide a $1,000,000 contribution towards the costs of this development. This $1,000,000 directly lowers the contribution necessary from the ministry.

5.9 Financing Options

5.9.1 Alternative Procurement

Based on information about this project, BCBC Development Consultants provided the following information about the likelihood of using alternative procurement to fund this project.

"We are unable to state unequivocally that a P-3 is not available but from our experience we can state that in this case it is likely that, assuming no scope creep during construction and efficient procurement methods being used for capital construction, it would probably be more expensive to construct the Lodge through the alternative procurement method for the following reasons:

1. *One of the attractions for alternative procurement is the opportunity for the operator/developer to provide the same services at a lesser cost. As outlined in the discussion of Capital Funds (below) it is difficult to envisage an operator/developer being able to compete with the marginal service costs for the kitchen and housekeeping services that will be achieved utilizing the hospital facilities;*
2. *the location of the community and the general economy of the interior will present additional costs to a provider through the P-3 method. The first significant cost will be the requirement by a lender for more equity in the project due to the risk that will be determined by lenders due to the location, economy and size of the project. Secondly, lenders will require an interest premium for the mortgaged amount due to the increased risk;*
3. *the chances of finding an operator/developer who will enter into simply a limited time operating agreement are marginal because of the risk to the operator of funding being discontinued at the end of the operating agreement which may result in the operator being faced with an under - utilized facility;*

The most obvious method of overcoming (3) above is to simply operate the facility through two agreements:

i) an operating agreement entered into directly with the operator, which can be for a limited period due to the reduced risk to the operator; and

ii) a lease agreement with the developer for the facility.

This approach would permit either the lodge to be constructed on the hospital site through subdivision and lease or sale of the proposed site to the developer or be constructed on any other site the developer may propose. The board through an operating agreement could then operate the facility if located on the hospital site and the operating economies could be achieved. However, in this instance the problem with this approach, whether on the hospital site or another site, would be that the resulting lease agreement in all likelihood would be a capital lease. There are three criteria for determining if a lease is a capital or operating lease:

a) the lease term must not exceed 75% of the life expectancy of the building;

b) the present value of the lease payments must not exceed 90% of the capital cost of the building;

c) the building cannot be purchased at the end of the lease term for a bargain.

If a, b and c above are met then the lease is an operating lease. However it is very difficult to imagine a developer willing to risk the construction of a $7M building in a community of approximately 4500 people with no growth trend and with the current economic climate without certainty of recovering, at a minimum, their costs. This will then result in a capital lease, which by definition would have to be capitalized as debt on the tenant's books."

5.9.2 Capital Funds

If the NIRHB constructs the building there appear to be economies that will be achieved utilizing shared services with the existing hospital. The existing hospital is small and therefore the addition of the 50 - bed multilevel care facility will allow the hospital to achieve economies by providing at a minimum housekeeping and kitchen services to the lodge. In addition, by utilizing the hospital kitchen the construction cost of the lodge should be decreased by the cost of the kitchen and equipment.

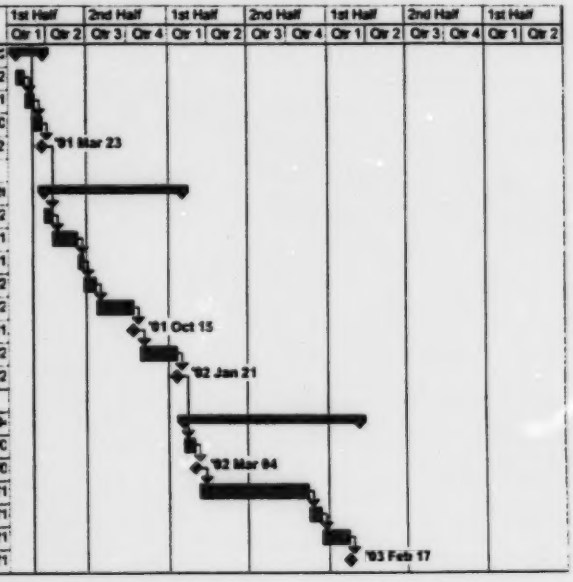
6.0 IMPLEMENTATION PLAN

One of the positive outcomes in replacing Omineca Lodge at a new site is that it allows the present site to continue to operate until the new site is completed. Once completed, the residents can be relocated from the old to the new site. This scenario is practical and feasible in that the redevelopment is made simpler and more user friendly. Exhibit 29 provides the preliminary implementation timelines for this project. A larger scale version is available in Appendix F.

Exhibit 29

PROJECT IMPLEMENTATION TIMELINES

ID	Task Name	Duration	Start
1	Project Request Submission	45 days	Mon 01/01/22
2	Part A Submission	15 days	Mon 01/01/2
3	Part B Submission	15 days	Mon 01/02/1
4	Ministry Review	14 days	Mon 01/03/0
5	Ministry Approval to Proceed	1 day	Fri 01/03/2
6			
7	Design Process	225 days	Mon 01/03/2
8	Selection of Program Consultant	3 wks	Mon 01/03/2
9	Detailed Functional Program	40 days	Mon 01/04/1
10	Functional Program Approval	10 days	Mon 01/06/1
11	Selection of Project Consultant Tear	4 wks	Mon 01/06/2
12	Schematic Design	60 days	Mon 01/07/2
13	Schematic Approval	10 days	Mon 01/10/1
14	Working Drawings	60 days	Mon 01/10/2
15	Working Drawings Approval	10 days	Mon 02/01/2
16			
17	Construction Phase	299 days	Mon 02/03/0
18	Tender Issued	20 days	Mon 02/02/0
19	Tender Award	5 days	Mon 02/03/0
20	Construction Period	180 days	Mon 02/03/1
21	Substantial Performance	20 days	Mon 02/11/1
22	Commissioning	9 wks	Mon 02/12/1
23	Occupancy	20 days	Mon 03/02/1



7.0 CONCLUSION

The population of the Nechako area is increasing, particularly in the 75+ age group who are most likely to require continuing care services. Based on current utilization figures, the number of IC2, IC3, and EC clients will increase significantly between 2001 and 2015. Given the Continuing Care Renewal Strategy of decreased residential bed utilization, particularly for those with lower care needs, we assume that the majority of IC2 and IC3 clients will be cared for in alternative settings in the community. Given this assumption, the proposed 50 bed facility is a reasonable number to accommodate the current population and the anticipated future needs to 2010.

In order to decrease residential bed utilization, additional community services must be developed and in place to accommodate seniors in the community. A variety of these additional services are proposed for inclusion in the new multilevel care facility including an adult day care centre, beds for palliative care, respite, and transitional care, and visiting occupational therapy, podiatry and medical services. In addition, converting the existing Omineca Lodge building units into supportive housing and/or assisted - living units, will reduce inappropriate utilization of residential care beds, thereby achieving cost savings.

This project represents an opportunity for the NIRHB to create a truly innovative "campus of care" for seniors in the Omineca Integrated Health Services Area. The provision of services such as Adult Day Care, respite and transitional care, will help reduce ALC days and act as a cost effective substitute for full time residential facility care. This project truly integrates the concepts put forward in the 2001 Continuing Care Renewal Strategy. It replaces a facility that no longer can meet the care needs of the residents of the area and that can not be renovated or updated to meet these needs. For these reasons this project should proceed with all possible speed.

Appendices

APPENDIX A

MATERIALS PERTAINING TO BUILDING CONDITION - OMINECA LODGE

Appendix 6a

Building Report for
STRUCTURAL REVIEW
BUILDING CODE REVIEW
ADULT CARE REGULATIONS REVIEW
of

OMINECA LODGE,
Vanderhoof, B.C.

June 14, 1999

Project Number 9966

Prepared for:
Northern Interior Regional Health Board

Prepared by:
Access Engineering Consultants Ltd.
Fergus J. Foley, P.Eng.
207-1527 Third Avenue Prince George, BC V2L 3G3 562-9345

and

RBB Architect
Rachel Beverley-Burton, MAIBC.
207-1527 Third Avenue Prince George, BC V2L 3G3 562-1083

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METHODOLOGY

There are a number of factors which make a re-evaluation of the building and it's suitability for use as an intermediate care facility prudent. These are:

- the age of the building,
- the change of use from the original design,
- the possible non-compliance of the building for Building Code requirements, due to the change in use,
- the possible non-compliance of Building Code requirements, due to subsequent renovations,
- the possible breach in the integrity of fire separations due to subsequent renovations, and
- the difficulties the staff and residents experience in using the facility as an intermediate care facility.

Elio Azzara requested Fergus Foley of Access Engineering Consultants Ltd. to evaluate the facility for compliance with the Building Code and the *Adult Care Regulations*. The results of this evaluation was to be prepared in a report, which is to be included in a report by Elio Azzaro for submittal to the Northern Interior Regional Health Board.

On June 9th, 1999 Fergus Foley of Access Engineering Consultants Ltd. and Rachel Beverley-Burton of RBB Architect visited the Omineca Lodge and reviewed the building. The review was limited to a visual inspection.

Mr. Foley and Ms. Beverley-Burton met Karol Henrott, Director of Resident Care, and other members of the staff. The Director and Staff offered comments with regard to the issues they experienced in working at Omineca Lodge.

The original architectural drawings by Allan Greenwell, Architect, were made available for review, as well as part of the report evaluating the facility to grant the intermediate care license.

BACKGROUND

Introduction to the building.

LOCATION

Omineca Lodge is an intermediate care facility, located on Louvain Street in Vanderhoof, B.C. It is at the edge of a residential neighborhood and is adjacent to a park that borders the Nechako River.

BUILDING BACKGROUND

The facility was designed as a senior's residence in 1977 by Alan Greenwell, Architect. The Electrical and Mechanical Consultant was E. P. Church and Associates Ltd. and D. C. Dennis Engineering Ltd. was the Structural Engineer.

The building was a flat-roofed, two storey building with a walk-out basement under the west wing. The central portion of the building contained the entry, lounges, dining room and kitchen. Twenty nine suites were provided in the east wing to accommodate thirty six residents requiring some personal care. Eighteen suites were provided in the west wing to accommodate eighteen self-care residents.

The building has undergone two significant renovations. First, the building was sprinklered in the early 1990's, and secondly, a pitched roof was built over the flat roof. Other renovation work included replacing the opening windows in each suite, adding additional strapping and insulation over the concrete block walls in the end suites and installing fire rated doors midway along of the east wing corridor.

PRESENT USE

As noted above, the building was originally designed as a senior's residence with eighteen self-care resident suites and thirty six beds for residents requiring care. The building facilities and the size of rooms were designed for residents with a considerable degree of self sufficiency and mobility.

Over time, the resident population has aged and the requirements of the community have changed. Now, twenty two of the residents use a walker or a wheelchair, many suffer from dementia, and the overall level of care required is much higher. In

addition, some residents are at the upper spectrum of intermediate care and require aspects of extended care.

Omineca Lodge is currently described as an intermediate care facility. Because the facility did not meet all of the *Adult Care Regulations*, it was grandfathered to be allowed to provide care for thirty-six intermediate care residents and eighteen self-care residents.

SITE DESCRIPTION

The building is located on a rectangular site consisting of typical urban lots. It borders Louvain Street to the north, an apartment site to the east, a lane to the south and a park to the west. The length of the building runs east/west, with the front of the building facing north. The main entrance is on the north, and the staff entry and loading is from the lane on the south side.

There is outdoor space for resident use on both the north and south sides of the building. The patio facing south is fenced, and is accessible from the main floor. The larger patio, also fenced, is used for BBQ's and activities requiring larger space. This patio faces north, and is accessible from the basement level. The gate may require upgrading to allow use by residents with dementia.

There is adequate space for both visitor parking on the north side of the site and staff parking on the south side of the site. The visitor parking backs out onto an unpaved dead end section of Louvain Street. Paving the visitor parking lot would improve access for all visitors, but is essential for elderly visitors or those requiring use of a walker or wheelchair. (It was noted by Karol Henrott that 90 year old residents have 70 year old children who are visitors!) The designated handicap stalls should be identified.

There is an existing ramp to the main entrance. A sidewalk is required across the front of the parking stalls to provide access from all stalls to the bottom of the ramp.

The staff parking stalls no longer meet current safe practice design. Drivers must back out into the lane, which is a safety hazard.

Outdoor wheelchairs are parked at the main entry. The area for storage of outdoor wheelchairs appears to be inadequate, and reduces access to the building. Battery chargers and other miscellaneous equipment clutter the entry.

BUILDING DESCRIPTION

STRUCTURE, EXTERIOR, MECHANICAL

STRUCTURE

In the original design, the end walls and the two firewalls, one on either side of the central block, were masonry concrete block walls. The firewalls are no longer classified as firewalls as they do not penetrate the roof assembly. (See photo #1)

In the lower level, the walls are concrete block and the floor and ceiling are concrete slabs. The crawlspace under the east wing has concrete block pony walls supporting 2x8 floor joists.

Aside from the four masonry concrete block walls, the structure of the remainder of the building is wood frame with 2x10 floor joists for the second floor and two sets of wood trusses for the roof. The original flat roof trusses and the later addition of pitched roof trusses.

The original drawings do not identify the fire separations or indicate the fire resistance ratings of the various assemblies. The corridors, as shown on the drawings indicate they probably were considered to be a fire separation with a forty-five minute rating. The interior suite wall and ceiling finish is drywall. There is drywall above dropped ceilings in the corridor and bathing rooms. The drywall no longer acts as a continuous fire separation, as there are many holes in it, especially in the bathing room areas.

EXTERIOR AND GRADING ISSUES

Overall, the exterior of the building is well-maintained and in good repair. The additions and renovations match the style of the building well.

The primary problem is that of drainage. The grade slopes towards the building in many places. (See photo #4) It was raining during our visit and we observed many puddles along the face of the building. (See photo #2)

The problem of drainage is worsened by the inadequate number of gutters. There is a large roof and on the north east section, only two gutters allow water to drain off the roof. We observed water pouring over the edge of the gutters and ponding along the

face of the building. (Perhaps the gutters may also require cleaning)

In spring, run-off from Louvain Street, ponds on the sidewalk. This often freezes making an 'ice rink', which represents a significant barrier to both residents and their guests.

There appears to be some signs of water damage in the east end of the crawlspace.

We checked the location of the flood plain, as the building is close to the river. It would appear that the basement is 300mm above the 200 year flood plane level.

MECHANICAL SYSTEM

The building is heated by hot water heating. There is no air-conditioning. The kitchen is not heated, but is air-conditioned. We were not able to evaluate mechanical equipment, as it was locked on the day of our visit.

There are a number of issues that are experienced by the users of the building. These are:

- Due to the lack of space one of the resident beds in the double rooms is placed against the radiator. This must be uncomfortably hot for sleeping. (See photo #5)
- The kitchen staff are forced to wear heavy clothing and boots during the winter, due to the lack of heat. This decreases their range of motion and mobility and increases their risk of accident or injury.
- In the suites, the radiators are located directly under the only operable window. This increases the potential risk of the pipes freezing if a window is left open. Given the fact that some of the residents experience forgetfulness, this is a real risk, and has occurred in the past with extensive damage.
- Due to the use of the facility and the desire for privacy and security, cross-ventilation is not always possible. In addition, the large glazed portions at the ends of the corridor and in the dining room increase thermal heat gain during the summer months. A comfortable ambient temperature cannot always be maintained during the summer.

BUILDING CODE REVIEW

OVERALL BUILDING REQUIRENTS

CLASSIFICATION OF BUILDING

Given the existing structure, and use of the facility, the building is classified as a Group B Division 2 occupancy. This is an Institutional occupancy in which persons, because of age, mental or physical limitations require special care or treatment.

FIREWALLS AND BUILDING SIZE

When the facility was first constructed the two firewalls divided the building into three separate "buildings". These three buildings were:

- the east wing with a Group B occupancy (Institutional),
- the central wing with a Group A occupancy (assembly activities, such as lounges and dining rooms,) and
- the west wing with a Group C occupancy (residential self-care suites).

As originally designed, the facility met code requirements for the area allowed for each occupancy. When the new pitched roof was installed the firewalls were not extended above the new roof. (See photo #1 & #3). This meant that the firewalls were no longer firewalls, and therefore the building could not be divided into three separate "buildings". At that point, the building became one building with two different occupancies. One occupancy was a Group B Division 2, which accommodates the care facility use and the second occupancy was a Group C, which accommodated the self-care residential use.

In the case where two occupancies occur in one building, the requirements for both occupancies are evaluated. Whichever has the most stringent requirements is the governing occupancy, and those requirements are applied to the whole building. In this case, the most stringent requirements are for the Group B Division 2 occupancy.

NUMBER OF STOREYS

The residential bedroom portion of the facility is two storeys high. Under the British Columbia Building Code1998, the walk -out basement is defined as a storey. As described above, the facility is one "building", so the whole facility must be defined as a three storey building.

BUILDING SIZE ALLOWED

Under Section 3.2.2.39 of the B.C. Building Code 1998, a three storey Group B Division 2 building is allowed if it is sprinklered, less than 800 sq.m. and if it is of non-combustible construction. Omineca Lodge exceeds the area allowed, and as a wood frame building, is combustible, and therefore is not allowed. In addition, the Lodge may not meet the other requirement of one hour fire resistance ratings for the floor assemblies and load-bearing walls.

There is no easy way to comply with Section 3.2.2 *Building Size and Construction Relative to Occupancy.* The usual way to achieve size and construction compliance, is to construct fire walls and create smaller "buildings" with less stringent requirements. If the non-functional firewall separating the self-care residences from the central block was restored and extended above the sloped roof, the facility, would become two "buildings".

The care facility "building" (east wing and central block) would then meet the size allowed under Section 3.2.2.40 and combustible construction would be allowed.

The residential "building" (west wing) meets the size requirements allowed under section 3.2.2.48 and combustible construction is allowed.

So, if the firewalls are restored, the structure will then be subdivided into three separate "buildings. Each of which will meet the fire rating requirements

The original drawings did not label the fire resistance ratings of the wall and floor assemblies and the actual assemblies can not be verified with a visual inspection. The fire resistance ratings required at the time of construction (National Building Code 1975), at the time of the renovations (B.C. Building Code 1983), and at present time (B.C. Building Code 1998) are listed below.

Original Design
Used National Building Code 1975 Combustible allowed

	load bearing structure	roof assemblies	floor over basement	floor assemblies	mezzanine assemblies
Group B2 east wing	45 min	45 min	45 min	45 min	not listed
Group C west wing	45 min	not listed	45 min	45 min	not listed
Group A centre block	45 min	45 min	45 min	45 min	45 min

It should be noted, that the definition of grade in 1975 Code, allows the lower level to be called a basement, not a storey. This allows the building to be called a two storey building and the building meets 1975 code requirements for building area allowed and fire resistance ratings.

Renovations
Probably used British Columbia Building Code 1985 Noncombustible

	load bearing structure	roof assemblies	floor over basement	floor assemblies	interconnected floors
Group B2 whole facility	1 hour	1 hour	1 hour	1 hour	not allowed

By 1985, the definition of grade and first storey had changed so that under the 1985 Code and later Codes, the lower floor is no longer a defined as a basement but as the first floor and thus redefines the building as a three storey building.

We are assuming that the decision to put in sprinklers was in response to a change in use to a more institutional use, and with these renovations and change in use, the building no longer meets code requirements and was required to meet at the time.

Current Requirements
British Columbia Building Code 1998, Non Combustible

	load bearing structure	roof assemblies	floor over basement	floor assemblies	interconnected floors
Group B2 whole facility	1 hour	not listed	1 hour	1 hour	not allowed

As noted above, the building does not meet current code requirements for non-combustible construction, or for the required fire resistance ratings.

Included below, are the fire resistance ratings required if the fire wall separating the centre block from the self-care suites were restored. It should be noted that the fire resistance ratings for the self-care suites are in excess of the ratings required at the time of construction and would have to be verified and upgraded if necessary.

British Columbia Building Code 1998 , If fire wall is restored Combustible allowed

	load bearing structure	roof assemblies	floor over basement	floor assemblies	interconnected floors
Group B2	45 min	not listed	45 min	45 min	not allowed
Group C	45 min	not listed	45 min	45 min	not listed

INTERCONNECTED FLOORS

The floor areas containing sleeping rooms of Group B Division 2 occupancy shall not be constructed with interconnected floor spaces (Section 3.2.8.1.(3)). Thus, under the present occupancy, the walkway with openings to both the dining area and lounge area is not permitted. (See photo #6)

In addition, the glazed opening between the second floor lounge and the main floor lounge is not a fire rated opening and therefore is not permitted. In both instances, at the walkway and between the lounges, a rated fire separation is required and all openings in that assembly must also be rated. The present windows should be replaced with steel frames with either wired or fire rated glass. In addition, the amount of glass will probably have to be reduced.

INTEGRITY OF THE BUILDING

Due to the age of the building, and the changes that have occurred over the years, it would be surprising if the integrity of the original fire separations was still intact. We reviewed the building for breaches in the fire separations, and for any errors in building construction. The following is a list of our observations, based only on a visual review of the building.

- The crawlspace vapour barrier was not installed correctly. (See photo-___) It has no covering and was not sealed to the footing. There appears to be no ventilation and the crawlspace has a slightly musty smell. There are some signs of water marks on the east end wall, but no signs of rot with the exception of some on the form work for the footing which was left in place and not removed at construction time. The crawlspace feels warm and has rigid insulation glued to the concrete walls.
- The locker room adjacent to the elevator in the basement has many wires crossing the ceiling and penetrating into the adjacent crawlspace. The gyproc ceiling at this location has many holes in it to accommodate the cables and wires. The floor joists are plainly visible and the fire rating is nonexistent. (See photo #7)
- The gyproc ceilings in the bathing and linen rooms have many holes in it to accommodate plumbing renovations. The ceiling no longer acts as a fire separation due to the holes. (See photo #9)
- Handrails along the corridor and stairs meet old Code requirements, but no longer meet current Code requirements for handrail grip and height above the floor. (See photo #10)
- Some changes have been made to the plumbing systems. The changes have been made with plastic (i.e. combustible) piping instead of noncombustible iron or copper pipes and it does not meet Code requirements. (See photo #9)

STAFF FACILITIES

The staff room has only one washroom for both sexes. With a day shift of ten people, regulations require one per each sex.

HANDICAP ACCESSIBILITY

The Omineca Lodge was designed and constructed before the requirements for persons with disabilities were written. Given that, the original design did make attempts to accommodate persons with disabilities. However, twenty-two of thirty-six of the current residents use a wheelchair or a walker, and from a practical point-of view, it is useful to compare the current code requirements against the existing facility.

The following list of requirements are missing from the facility:

- H/C Parking stalls should be identified with a sign.
- The distance between the two sets of doors at the main entry is less than the distance required by approximately 1'-4".
- The minimum clear opening at doorways is 32" and the existing width is 31 ½". (See photo #12)
- The handrails on either side of the corridor are unacceptable as the grip is difficult to grasp and are too low. (See photo #10)
- Tactile warning strips are required at the top of stairs.
- Grab bars are required beside the H/C toilets. (See photo #13)
- The height of the toilet rim is to be 430mm. (See photo #13)
- The washrooms must be large enough to accommodate a wheelchair turning radius.
- The toilet lid is to be bolted down. (See photo #13)
- The shower stall is to be 1.5m by .9m, with an entrance of 1.5m. There is to be no curb at the shower entrance. The floor area must be large enough to accommodate a wheelchair turning radius and the clear area in front of the shower is to be .8m by 1.5m.
- An area beside the bed of not less than 1.5m radius is required as a wheelchair turning radius. (See photo #20)
- Accessible heights for closet rods, counters, shelves and electrical outlets. (See photo #15)
- The area under the counter in front of the sink is to be open. (See photo #15)

- The kitchen facilities in the designated handicapped suites do not meet handicap requirements for access to the counter, the sink, the stove and the drawers.
- None of the bathing facilities are fully handicapped accessible. The shower stall is too small, has a curb and has insufficient room for a turning radius. The new tub is larger than the previous tub and there is insufficient room adjacent to the tub for a turning radius. (See photo #16 & #17) The 'residential style' bath is completely inaccessible to a person with disabilities and is difficult for the staff as it can only be accessed from one side.
- Few suites have handicap accessible washrooms. Many residents have a difficult time using the washroom facilities as the doorways are too narrow and the rooms are too small to accommodate a wheelchair turning radius. Proof of this is that every door and many of the walls have pieces gouged out of them by the wheelchairs hitting and rubbing against them. Not only are the door opening widths too narrow and the washrooms too small to turn a wheelchair around in, the doors are pocket doors which are difficult to close by able-bodied persons. The Building Code defines the maximum amount of pressure allowed to open a door and what kind of hardware to install. The pocket doors with finger pull tabs do not meet either criteria. (See photo #12)

EXITING

The exterior level access from doors at fire stairs provides safe exiting for elderly residents. In areas where the grade was not at floor level, retaining walls and ramps were provided. (See photo #18) However, there are a number of issues on the interior of the building that do not meet Code or are a safety hazard. These are:

- The large glazed windows at the ends of the corridors could look like an opening the exterior to disoriented people, especially in a stressful event such as a fire. (See photo #19) Handrails across the opening are required.

- The exit signs are original and the directional arrows are not clear. This contributes to the issue of the window being confused as an exit as described above. (See photo #19)
- The doors at fire exit stairs are not labeled with a ULC rating and appear to have a glazed section larger than allowed.
- Mirrors adjacent to exits cause confusion in a panic and are not allowed by Code. The mirror at the second floor elevator area should be relocated.
- Residents gathering in the front foyer reduces access to the exit and makes it difficult to continue along the corridor.
- Exit signs are required in the corridor on both sides of the fire doors midway along the east wing corridor.
- All exit doors are controlled by electric locks that are operated by key pads. This is necessary because of the high number of residents suffering from dementia that are inclined to wander off. These keypads and electric locks are deactivated by the fire alarm system, however, the Building Code states that it must be possible to leave a building in any emergency without hinderance and without requiring special knowledge. Buildings with detention quarters are to be designated as Group B Division 1, which only allows sprinklered, non-combustible construction.

BUILDING CODE REVIEW

CARE FACILITY REQUIREMENTS

CORRIDOR & DOOR WIDTHS

A corridor, in which it may be necessary to move a resident in a bed, shall not be less that 2, 400mm wide (Section 3.3.3.3(2)), with a maximum clear width of doorways of not less than 1,050mm. The existing corridor width at the Omineca Lodge is 1,854mm and the clear width of existing doorways is 800mm. Neither the existing corridor width or the existing clear doorway widths meets the B.C Building Code 1998 requirements. These were similar requirements to the 1975 Code, but the occupant use did not necessitate that provision at the time of construction. (See photo #10)

While it is not an everyday requirement to move a resident in a bed, it is necessary in the event that a resident needs to be transported to the hospital. Given the use of the facility as an intermediate care facility, with some residents starting to require extended care, there is a need for a wider corridor to allow moving a resident in bed.

The Building Code requires that the doors in the mid corridor should have one leaf that opens in each direction. The existing doors swing in one direction only.

FIRE COMPARTMENTS

The floor area containing residents' sleeping rooms is to be divided into no less than two fire compartments having a fire resistance ratings no less than one hour. (Section 3.3.3.5 (2) and Section 3.3.3.5 (4))

The original design did not satisfy this requirement and a later renovation installed the fire rated doors mid-way along the corridor. However, the original drawings did not indicate fire resistance ratings, and the code only required 45 minutes, so it cannot be confirmed that the suite walls and the corridor walls which form part of the fire compartment walls are in fact rated for one hour. While fire rated doors were installed as part of this fire compartment, Section 3.3.3.5 (6) further requires that the door opening be weather-stripped. Currently, without the weather-stripping the existing doors do not meet Code requirements.

Floor areas on either side of the fire doors are required to accommodate residents from the adjacent fire compartment. Twenty-seven and a half square meters (27.5sq.m.) is required on the east side of the fire compartment, which means the location of the fire doors must be at least fifty feet from the end of the corridor. The existing door location, may be just short of fifty feet, and may not meet the 1998 B.C. Building Code requirements.

FIRE SEPARATIONS

BETWEEN SLEEPING ROOMS AND ADJACENT ROOMS

Walls between resident sleeping rooms and adjacent rooms are to be constructed as fire separations (Section 3.3.3.5 (9)) and the walls between the corridor and these adjacent rooms are also to be constructed as fire separations (Section 3.3.3.5 (10)). This means that the walls around rooms such as the laundry, staff room, hair dressing salon, bathing rooms, medication storage and the meeting room must be constructed as fire separations.

It is not confirmed that all of the walls around each of these rooms extends through the joist space. It is also not confirmed that the entire ceiling area is drywalled to the underside of the joists. We observed holes in the drywall in the linen storage and bathrooms. In these rooms, at least, the fire separation has been breached.

The doors and door frames to these adjacent rooms are part of the fire separation and must be constructed to act as a barrier to the spread of smoke and fire until some response is initiated. Some of the requirements for a door in a fire separation are:

- be equipped with a self-closing device
- not exceed maximum area of wired glass panels. Many of the doors appear to have more glass than allowed.
- be a rated closure with a label issued by a certified rating agency. Most of the existing doors and frames are not labeled with their rating.
- be installed in conformance with NFPA 80 "Standard for Fire Doors and Fire Windows".

BUILDING CODE REVIEW

RESIDENTIAL GROUP C REQUIREMENTS

FIRE SEPARATIONS

Suites in a residential occupancy shall be separated from each other and the remainder of the building by a fire separation (Section 3.2.2.2 (1)). The original drawings did not define the fire ratings of the walls, so it cannot be confirmed from a visual review of the building if these walls are constructed as fire separations of the required fire resistance rating.

SOUND TRANMISSION RATINGS

Each dwelling unit shall be separated from every other space in the building by construction providing a sound transmission class rating not less than fifty (50). The original drawings did not indicate if insulation was installed and the sound transmission class cannot be confirmed through a visual review of the building.

ADULT CARE REGULATIONS

BUILDING REQUIREMENTS

INTRODUCTION

This section of the report will be limited to the requirements listed in the Adult Care Regulations, (consolidated Oct. 17, 1977), that are related to the building requirements. The comments are restricted to the deficiencies or partial compliances. A full description of requirements and compliances was prepared as a Residential Facility Assessment Instrument. There are some differences between this report and our evaluation (eg. compliance with the size of a double room). The Residential Facility Assessment Instrument ranked compliance within five options that included 'fully' and 'partial' as two of the choices. We found situations rated as 'partial' that were so partial they were inadequate. For example the furniture provided in a double room. In such cases we have noted non-compliance as the outcome.

DOUBLE BEDROOMS

The minimum floor area of a double occupancy bedroom is 18 sq.m. (5.3 sq.ft.). The existing double occupancy bedrooms, excluding hall, closets, etc. are 14.1 sq.m. This is 22% less than the allowed minimum. Note that the sizes in the regulations are minimums, which makes the size of the existing double occupancy bedrooms even more inadequate.

There are nine double occupancy bedrooms which entails that eighteen of the thirty-six beds are in double occupancy bedrooms. The Adult Care Regulations allow 10% of the beds to be double occupancy (5.3 sq.ft.) and at 50% the facility is well over that limit.

The double occupancy bedrooms are so small that there is insufficient room to provide the minimum furniture required by the Adult Care Regulations (5.5). Two beds are provided, but both are pushed against the wall. This makes it difficult to make the beds and as one bed is against the radiator, it must be uncomfortably hot. Only one of the double occupancy residents has a wall lamp, an easy chair, a chest of drawers and a waste basket. The other resident has only a desk. Neither resident is provided with a mirror.

The double occupancy suites equipped with a handicapped accessible washroom do not have any storage space in the suite for either resident. The Regulations require a minimum 1.5sq.m. (4(b)) space for storage for each resident. There is storage space in the basement but it is inaccessible to many residents. The lack of storage space is compounded by the lack of furniture for one resident of each double occupancy bedroom.

RESIDENT BEDROOMS

In addition to the deficiencies noted above for the double occupancy bedrooms the following are deficiencies common to all the suites:

- The resident bedroom doors are too narrow. (5.3 (k)) Since twenty-two of the thirty-six residents require a walker or a wheelchair, the narrow door width becomes even more critical. A related problem is the width of the washroom door which is also too narrow. Gouges and marks at the door indicate ongoing damage from walkers and wheelchairs.
- While the rooms have adequate general illumination, the illumination required for tasks and reading activities are inadequate. (5.3 (l)) The lighting is inadequate because the location of the wall fixtures does not allow them to be used as task or reading lights. Also, in the double occupancy suites there are not independent controls for fixtures to allow each resident to control the illumination to suit there activity. Lately, the lighting is inadequate because the fixtures are controlled from a switch at the entry and Regulations require the resident to have a reading light that is switchable from their bed.
- The Regulations require an ensuite toilet and hand basin for every resident (6 (a)). Implicit in that statement is that the resident is 'able' to use the ensuite toilet and hand basin provided. Given the number of residents at Omineca Lodge who use a wheelchair or walker and who do not have a handicap accessible washroom, the Lodge does not come close to providing the intent of the regulation.

- The Regulations require a door lock that can be opened from the outside. The intent is to provide privacy with a level of safety. As discussed previously under Handicap Accessibility, the door hardware is difficult to operate and the door is awkward, if not impossible, for a resident to close. I suspect the doors to the washrooms are rarely closed and therefore the facility does not meet the intent of the privacy implied in the requirements.
- A grab bar is to be located beside each toilet and bathtub (7(c)). This regulation is only met in the suites with handicap accessible washrooms.

COMMON FACILITIES

The dining room (15) and lounge areas (11(a)) meet the Adult Care Regulations for thirty-six residents, but since they are also used by self-care residents they are undersized. Similarily, the outdoor areas on the lower level are inaccessible to most of the residents. The outdoor area available on the main level meets the minimum allowed for thirty-six residents (12) but is too small to additionally accommodate eighteen self-care residents.

Rooms for recreational activities are required (11(b)). All of these rooms are on the lower level and are inaccessible to most of the residents and therefore the facility does not meet this requirement. Many crafts and recreation programs are run in the lounge as the lower level rooms are inaccessible. This has resulted in increased damage and staining to the carpet in the lounge. (Since the carpet is not an "antibacterial" carpet, the staining and damage is extensive.)

Fresh water is to be available to residents in the lounge and outdoor patio areas (11(c)). A coffee bar is located in the dining room to meet this requirement. However, the height of the taps, the height of the counter, the crowding of the dispensing equipment and its location at a busy corner all contribute to the lack of an adequate level of safety for the residents.

There are less than the required number of bathing facilities on the ground floor (6(a)). The Regulations also state that the bathing facility must be appropriate to the needs of the residents. Not one of the bathing facilities fully meets the regulations. The inadequacies of each of these bathing rooms was discussed in Handicap Accessibility under the Building Code Review.

There are washroom and toilet facilities adjacent to the dining, lounge and recreational areas. They were designed prior to the inclusion of Handicap Requirements in the Code and are therefore not up to current Code standards (6(c)).

The existing handrails are lower than the height required in the regulations (9(b)).

STAFF FACILITIES

Adult Care Regulations require a staff workroom to be located on each floor which has a view of the entrances, exits and corridors (16(b)). The staff workroom on the main level has an excellent view of the corridor but does not have a view of the main entrance.

Both floors of the Intermediate Care Facility lack a utility room as described in the Regulations (16(d)). The main floor has a small utility room but does not have adequate space for a separate work area for clean and soiled work. The upper floor does not have a utility room.

A general purpose bedroom located in the vicinity of the staff workroom is required (16(e)). None has been provided.

USER CONCERNS

WHAT IS IT LIKE TO LIVE AND WORK HERE?

We met with the staff, and talked to many of the residents during our visit to Omineca Lodge. The following reflects some of the points raised by the user groups, but are not necessarily code issues.

- Fifteen of the residents suffer from dementia. They are not in a separate area but are mixed in with the general population. This causes many problems and conflicts, especially between roommates.
- Many of the residents tend to congregate at the entry, making it difficult to access the front door, or to continue along the corridor.
- Having resident bedrooms on two levels causes confusion and disorientation with many of the residents. In addition, the staff have a more difficult time keeping an eye on the residents or responding to calls as quickly or as efficiently as they would like.
- Having recreation rooms located on the lower level means that they are underused. Many of the residents are not able to make the trip on their own, so they are not able to access that area of the building. In addition, if a large group activity is planned on the lower level, the staff must spend considerable time and effort setting up a convoy to transport residents to the activity.
- While residents have lockers in the basement, many are unable to easily access the storage space due to ambulatory difficulties.

KITCHEN

The design and layout of the kitchen makes it difficult for the staff to work, and poses an increased risk of injury or accident. The following identifies the major issues of safety in the kitchen:

- The aisle is so narrow, the oven doors open into the serving area. Thus a worker could trip over the

open oven door as there is insufficient room to go around.

- There is not a separate hand-washing sink.
- The weather stripping at the back door is inadequate and snow and frost builds up during winter.
- As noted elsewhere, there is no heat in the kitchen, forcing the staff to wear boots and heavy clothing which reduces mobility and agility.
- The width of all the aisles are so narrow, that staff can not pass one another working at the counter without bumping into them. In addition, the freezer door cannot be opened without hitting a staff member working at the counter.

DISCUSSION and RECOMMENDATIONS

The building, as designed and constructed in 1977, appears to have met the B.C. Building Code 1975 requirements. As designed, the building for the most part, met the needs of the residents. Many of the issues facing staff would have been similar to the issues in 1977 and working conditions are less than ideal.

The changes and maintenance work to the building have disrupted the integrity of the fire separations and these require restoration.

Over time, with the aging of the resident population, the change in use to a higher level of care facility, the physical limitations and layout of the facility impede the care of the staff and affect the quality of life for both residents and staff. Some of these deficiencies are qualitative, others are quantitative and are in conflict with the requirements of the B.C. Building Code and the Adult Care Regulations.

It would not be possible to correct all the deficiencies (e.g. the location of beds on two levels), so even if the facility was renovated to correct as many deficiencies as possible, the facility would not be 100% successful as an Intermediate Care Facility.

The most significant deficiency, from a Building Code point of view, is that the building is a wood frame combustible building, and is required to be non-combustible. This requirement for non-combustibility was initiated by the change of use and the addition of the pitched roof which destroyed the separations provided by the firewall. The B.C. Building Code 1985, which would have been in effect at the time of the changes, had the requirement for non-combustibility, and the requirement is still applicable under the current code.

As discussed earlier, the correction of this problem can be achieved through restoring the firewall and upgrading the fire resistance ratings in the self-care west wing. The extent of the renovations would be very disruptive to the continuing use of the facility.

Given the extent of the renovations required, the cost of the work, the level of disruption and the fact that at the end of the renovations the facility would still not be fully successful as an Intermediate Care Facility, we recommend that it is not cost effective or productive to pursue that option.

Based on the findings of our report and our experience as Architects and Engineers, we make the following recommendations:

- The Lodge revert to it's original residential use.
- Double occupancy bedrooms be converted to large single occupancy bedrooms.
- Study ways to provide larger washrooms. This could perhaps be achieved by demolishing existing walls between two washrooms and making one large shared washroom.
- The Omineca Lodge building be renovated to the extent required to restore the required fire separations, and correct the items of non compliance that relate to exiting, fire separations, and resident health and safety. Any other items that can reasonably be addressed should be included in the scope of work.

A new one storey facility be constructed as an Intermediate Care Facility, which fully complies with all of the requirements of the B.C. Building Code 1998, and the Adult Care Regulations for the best possible quality of life and safety for the residents and staff.

ACCESS ENGINEERING CONSULTANTS LTD.

PROFESSIONAL ENGINEER
PROVINCE OF BRITISH COLUMBIA
J. F. FOLEY

Fergus Foley

Fergus Foley, P. Eng.

RBB ARCHITECT

REGISTERED ARCHITECT
RACHEL BEVERLEY-BURTON
BRITISH COLUMBIA

Rachel Beverley-Burton, MAIBC

APPENDIX A

Code Review

Building Analysis & Code Review

General Information:

Project # 9966 Date: June 14, 1999
Project: Building evaluation and report
Omineca Lodge

Client: Elio Azzaro, Northern Interior Regional Health Board
Contact Address: Northern Interior Health Board
Prince George Regional Hospital
2000-15th Avenue,
Prince George, B.C.
V2M 1S2
tel: **fax:** **e-mail:**
Other: Karol Henrott, Director of Resident Care
Contact Address: Omineca Lodge
242 Louvain Street
Vanderhoof, B.C.
tel: 567-2216 **fax:** 567-5377 **e-mail:**

Project Civic Address: Omineca Lodge
242 Louvain Street
Vanderhoof, B.C.
Legal Description:

Building Analysis & Code Review

Building Use: Intermediate Care facility and Senior Self Care Suites
Major Occupancies: Group B Division 2
Percent of Total: 62%
Minor Occupancies: Group C
Percent of Total: 38%
Total Occupant Load: 64
Applicable Building Code Sections:
Group C: 3.2.2.48, Group C, up to 3 Storeys, Sprinklered.
Group B Division 2: 3.2.2.39, Group B Division 2, Up to 3 Storeys, Sprinklered.
Codes Referenced: Building Code 1998, Building Code 1975,
Other Ref. Publications: Community care Facility Act, Adult Care Regulations.

Building Code Review:

Building Footprint Area: 1,180 sq. m.
Number of Floors: 3
Basement: partial, counts as a storey
Total Building Area: 3,069 sq. m.
Interconnected Spaces: yes, walkway and upper lounge
Self Care Suites: 1 bedroom 16 H/C accessible 2
Intermediate Care Suites: 1 bedroom 20 1 bedroom H/C accessible 4
2 bedroom 5 2 bedroom H/C accessible 4
Number of Streets: 2, possibly 3
Combustible or Non-combustible:
Non combustible required, existing building is combustible
Sprinklered: yes **Standpipe:** not required
Fire Alarm System: yes
Extinguishers: yes
Fire Suppression - other: hood in kitchen

Building Analysis & Code Review

Required Fire Resistance Ratings:

floor assemblies: 1 hour
walls: none specified
roof: none specified
structural supports: 1 hour
party walls:
corridors:
service areas:
adjacent rooms
exits: 1 hour
Fire Walls:
Fire Separations: 1 hour
Fire Stops:
Exits req'd:
Maximum Travel Distance:
Location of Exits:
Barrier Free Access:
Washrooms req'd: men ____ **women** ____ **H/C:** ____

Limiting Distance & Allowable Openings

	North	East	South	West
Wall Area				
Limiting Distance				
Allowable Openings				
Actual Openings				
Wall Construction comb. or non-comb				

Remarks:

APPENDIX B

Photographs

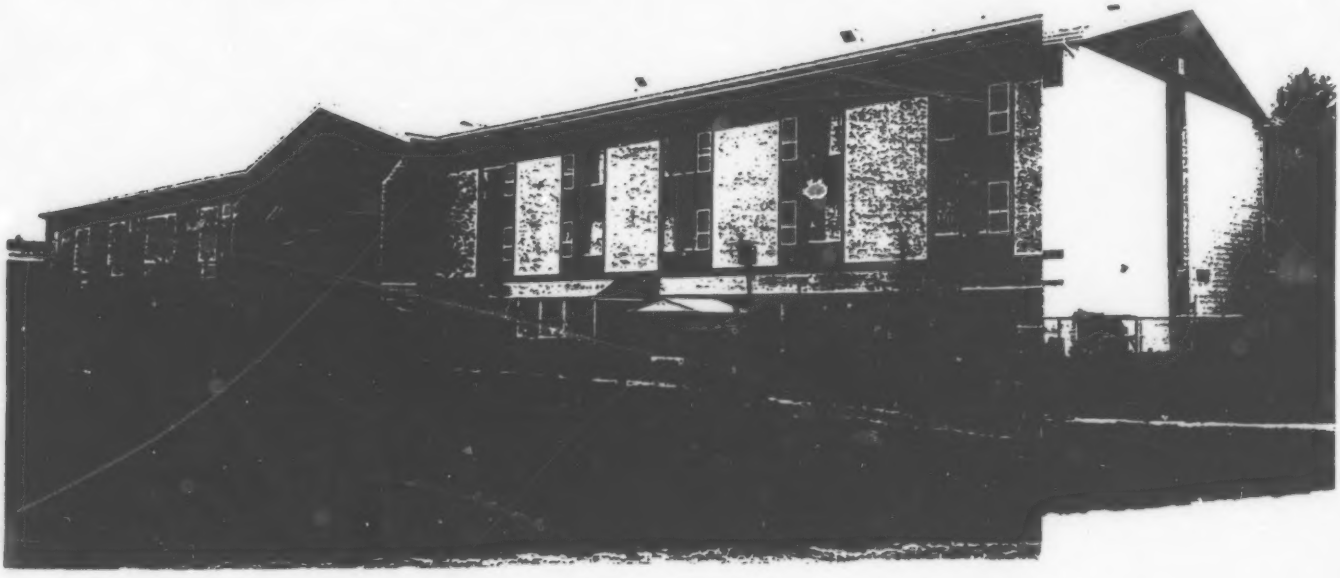


Photo #1 North view of Omineca Lodge. Note lower level at west end of building, disruption of firewalls by new pitched roof.

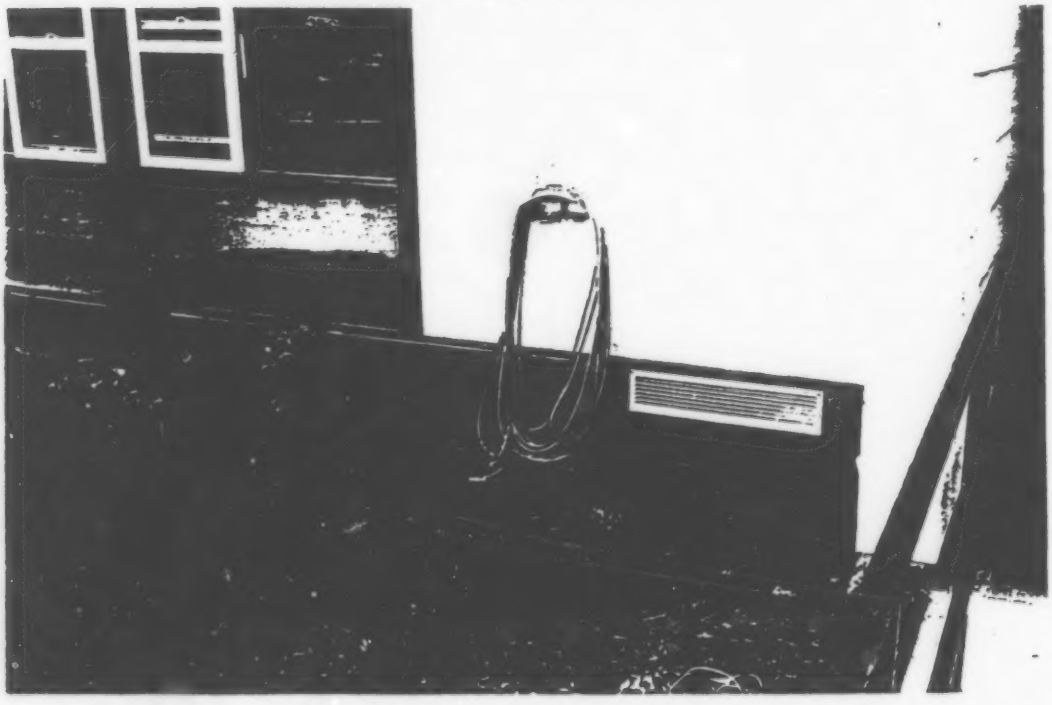


Photo #2 Puddles along exterior face of building

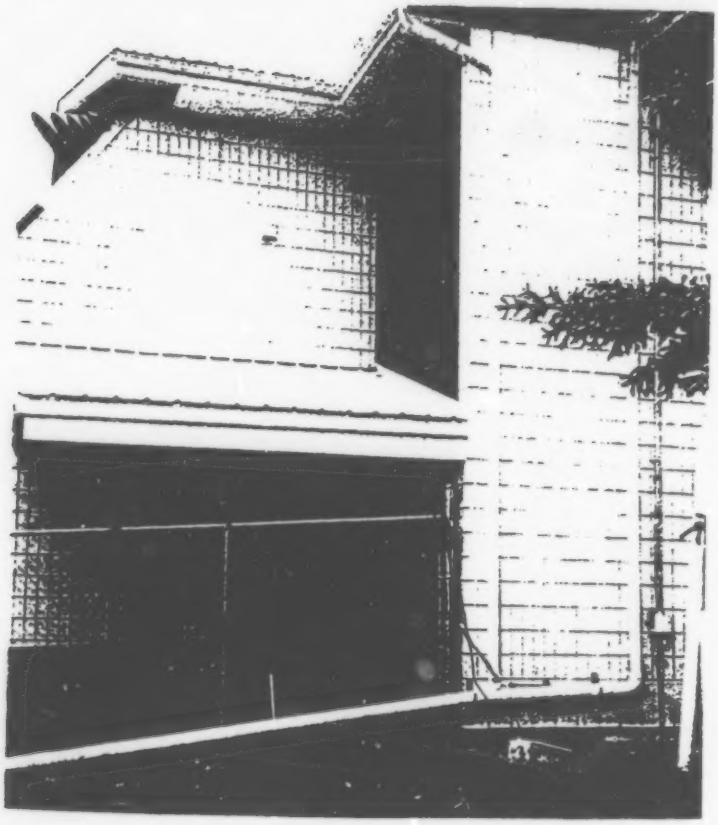


Photo #3 Exterior of building. Note heat wrapped gutters to drain water away from building, disruption of firewalls at roof and gas meter at exit.

Photo #4 Ground slopes towards building

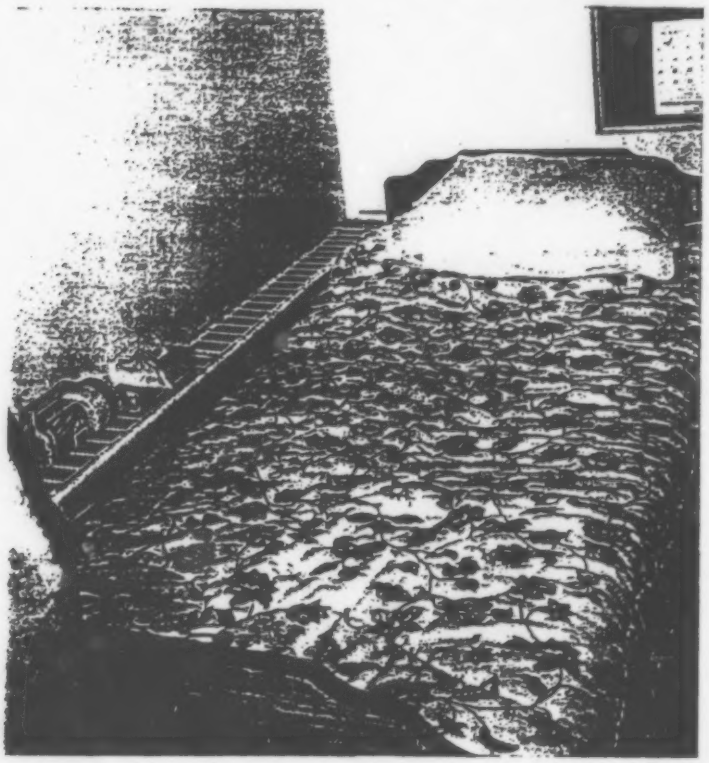


Photo #5 Double occupancy bedroom
Note: bed right against radiator and no reading light.

Photo #6 Interconnected floor area with lack of fire separation.

Photo #7 Drywall cut to accommodate wires.

Photo #8 Crawlspace vapor barrier installed incorrectly

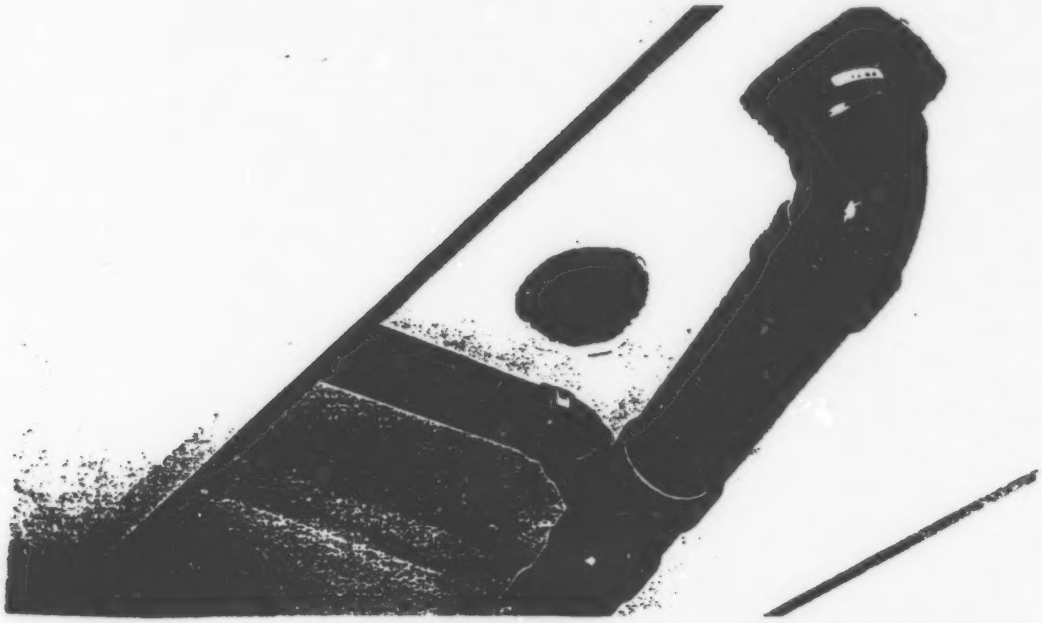


Photo #9 Holes in the gyproc resulting in lack of fire separation between floors. Note also combustible plumbing.

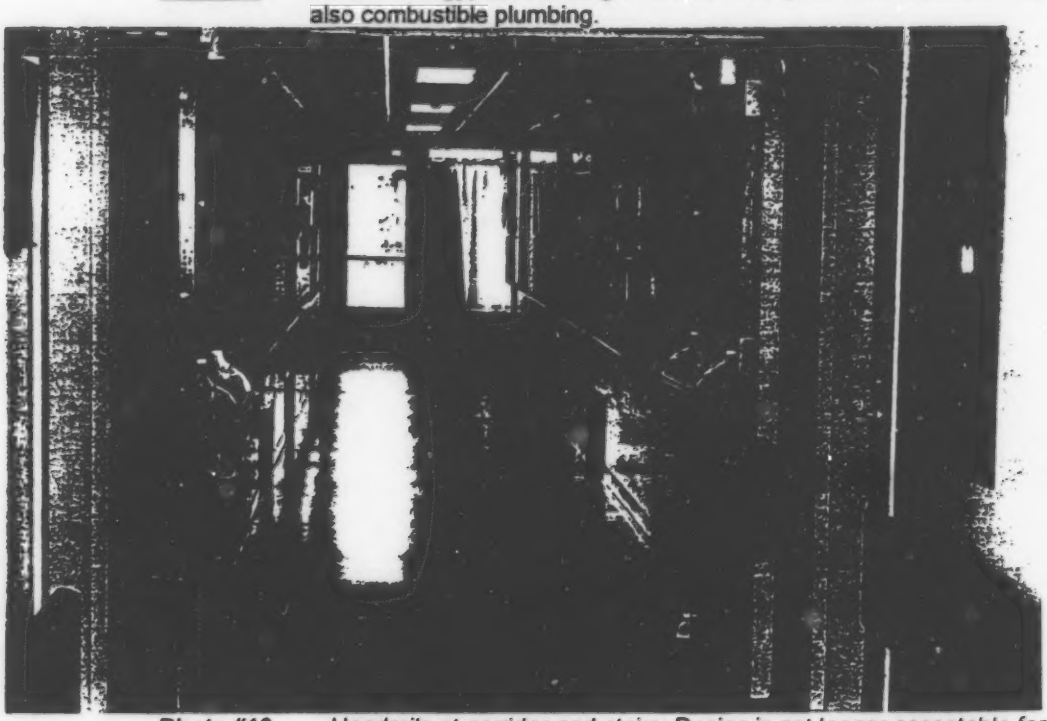


Photo #10 Handrails at corridor and stairs: Design is not longer acceptable for height or grip. Fire doors in corridor not equipped with exit signs. Curtain at the end of the hall can obscure exit.

Photo #11 Typical handicap washroom.

Photo #12 Door to typical washroom. Note marks on door and frame, pocket door and finger pull latch.

Photo #13 Resident demonstrating tightness in typical washroom. Resident had to remove footrest and had to enter washroom in reverse. Note: lack of grab bars, insufficient room for turning wheelchair, toilet rim lower than 430mm, pocket door with finger latch. Often the pocket doors were out of vertical and could not be fully opened further reducing the opening.

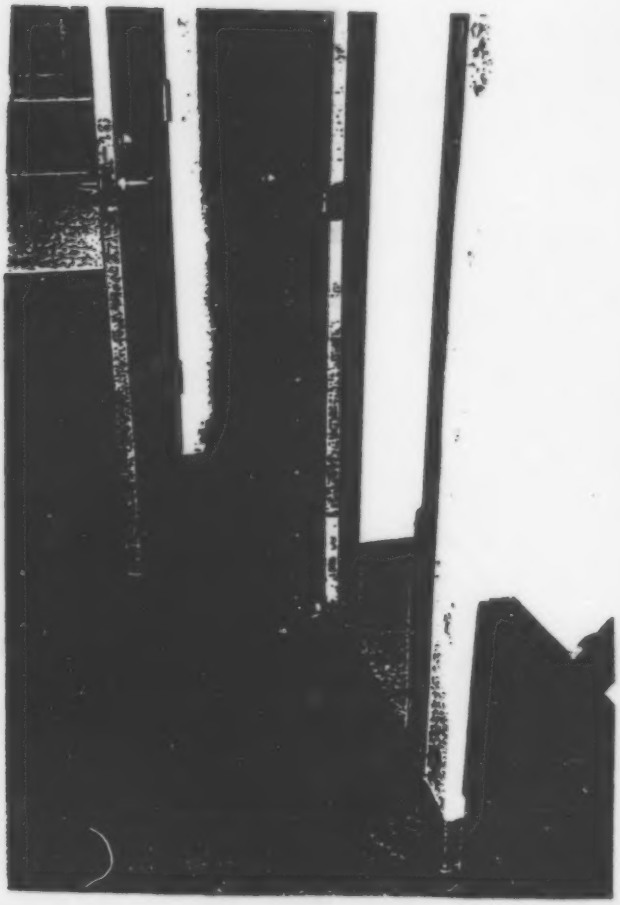


Photo #14 Note bumper guards at washroom doorway installed to minimize damage. Pocket doors with a thumb latch are difficult to operate, especially with the lack of room to turn inside the washroom to close the door.

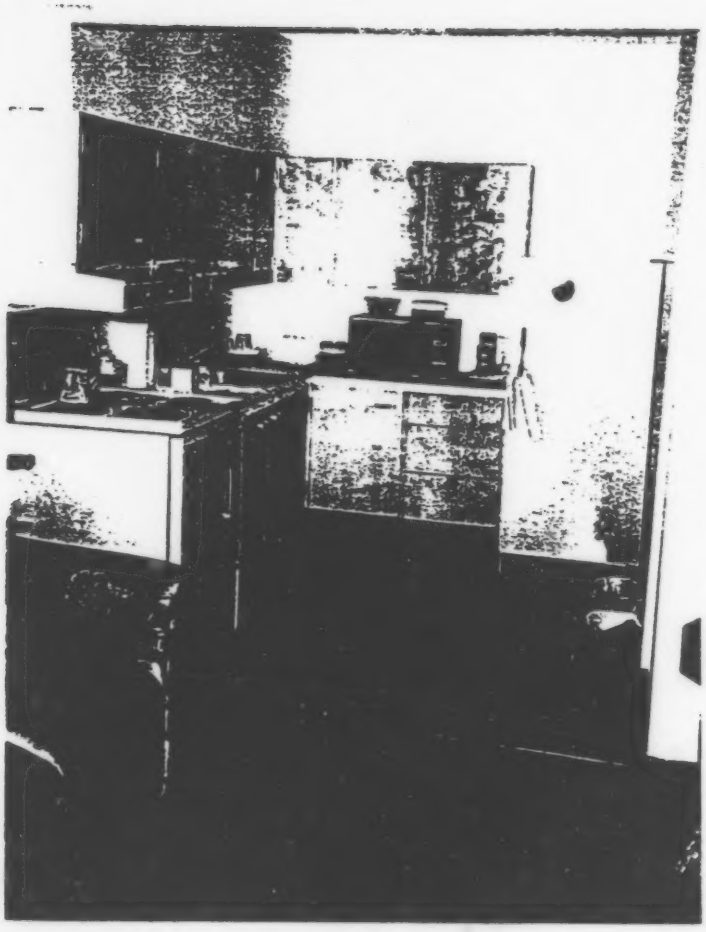


Photo #15 Kitchen in handicap accessible unit. Note: inaccessibility of upper cabinets, lack of opening under sink and difficult to reach stove controls.

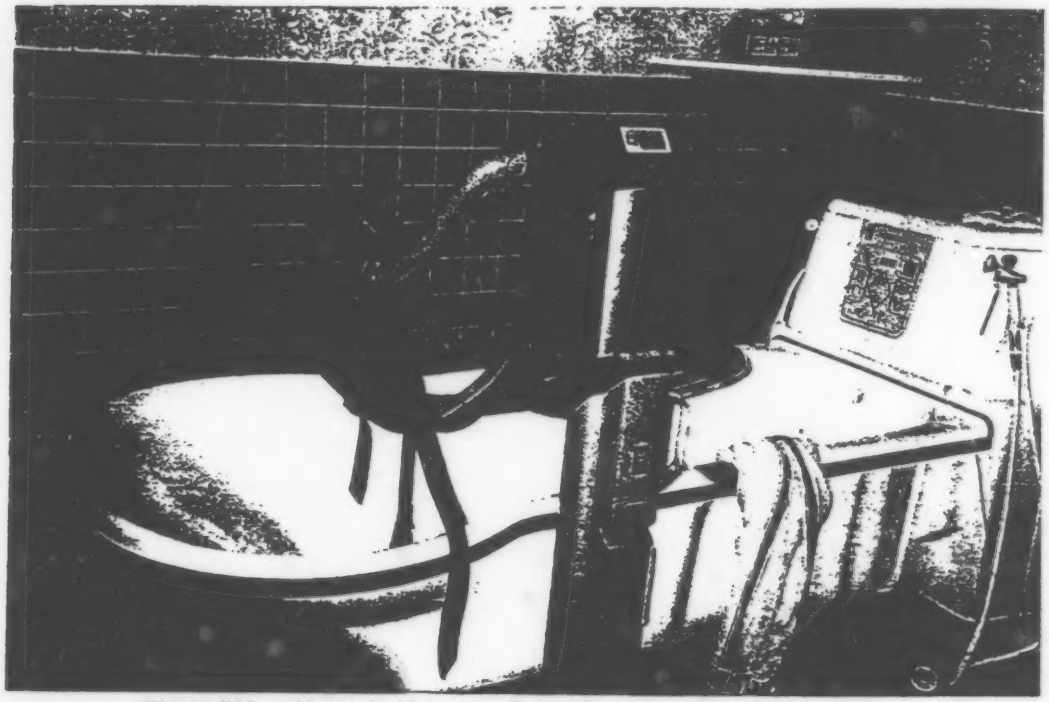


Photo #16 New tub. Note: insufficient floor area around tub.

Photo #17 New tub. Note: insufficient floor area around tub.

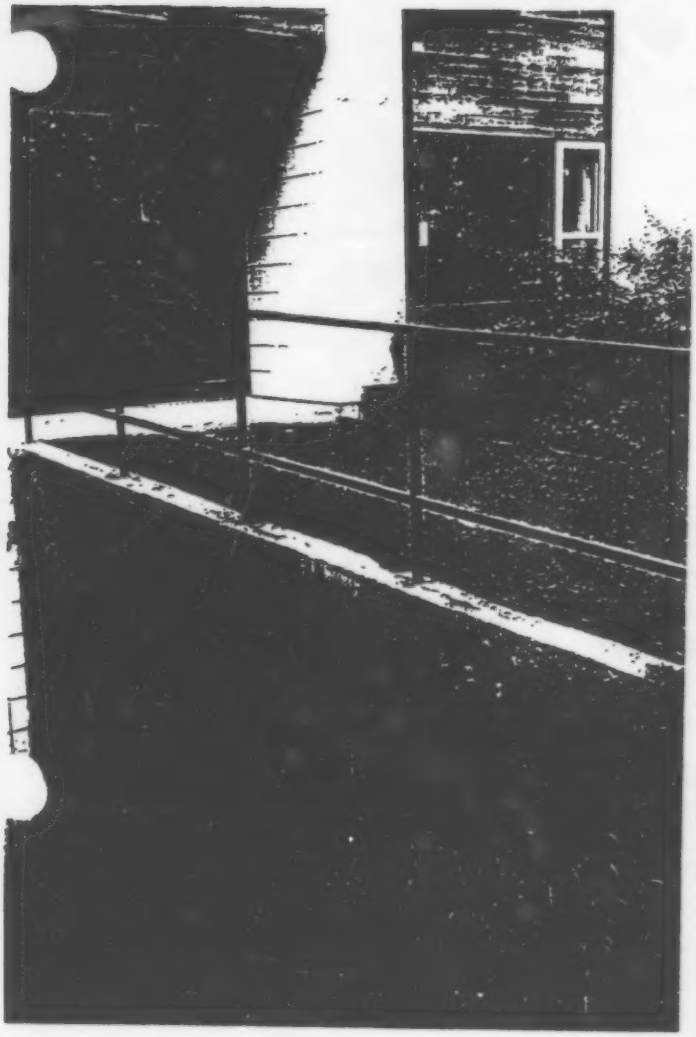


Photo #18 South west exit provide with sidewalk. A curb would improve safety

Photo #19 Window at end of corridor. Note: a rail at 3'-6" would increase safety and prevent confusion with actual exit. The direction arrow for the "EXIT" sign is hard to read.

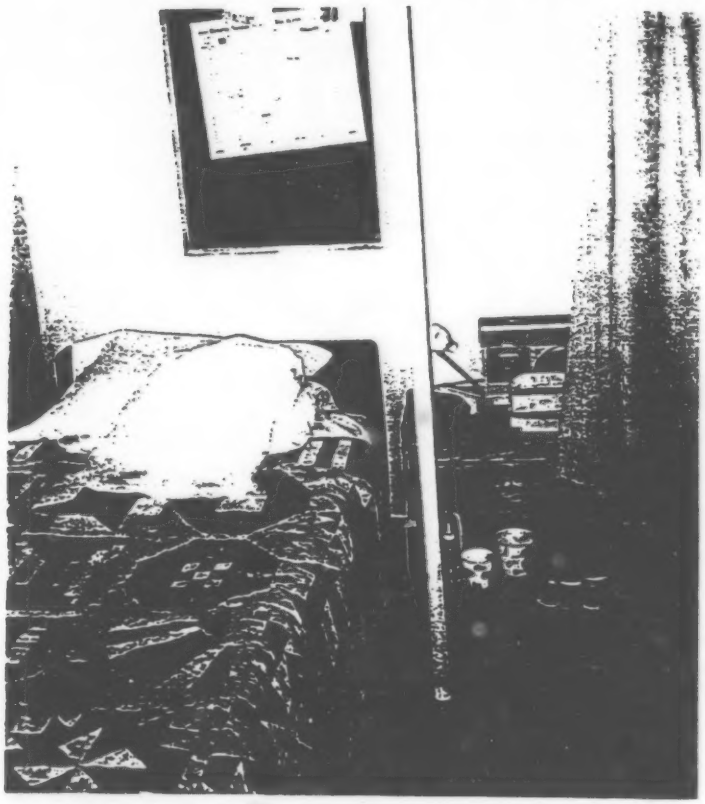


Photo #20 Bed in double occupancy room. Existing pole decrease area available for wheelchair turning radius.

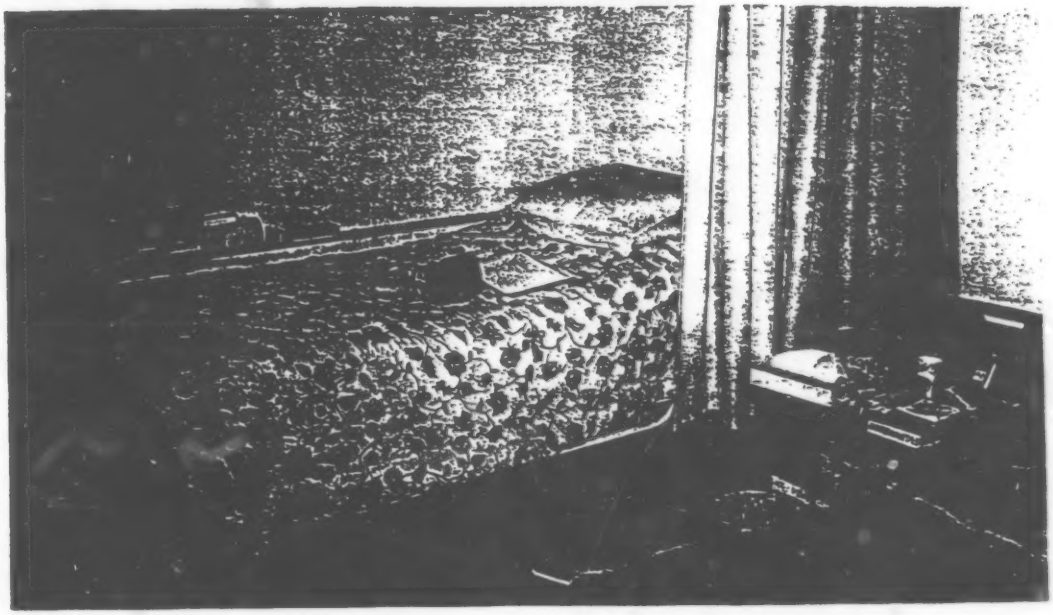


Photo #21 Double occupancy bedroom. Note: lack of reading light, lack of room for wheelchair turning radius and bed against radiator.

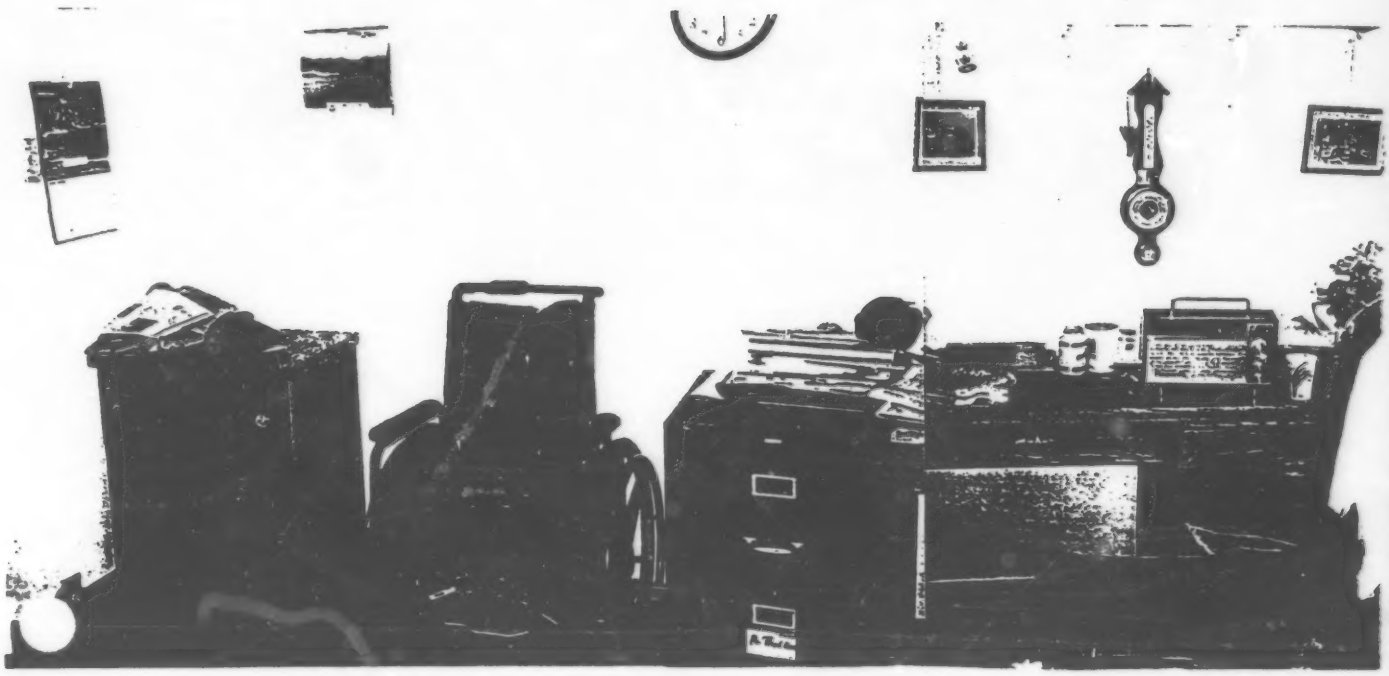


Photo #22 Typical furniture in double occupancy room. Note lack of second chest of drawers and chair and task lighting at chair.

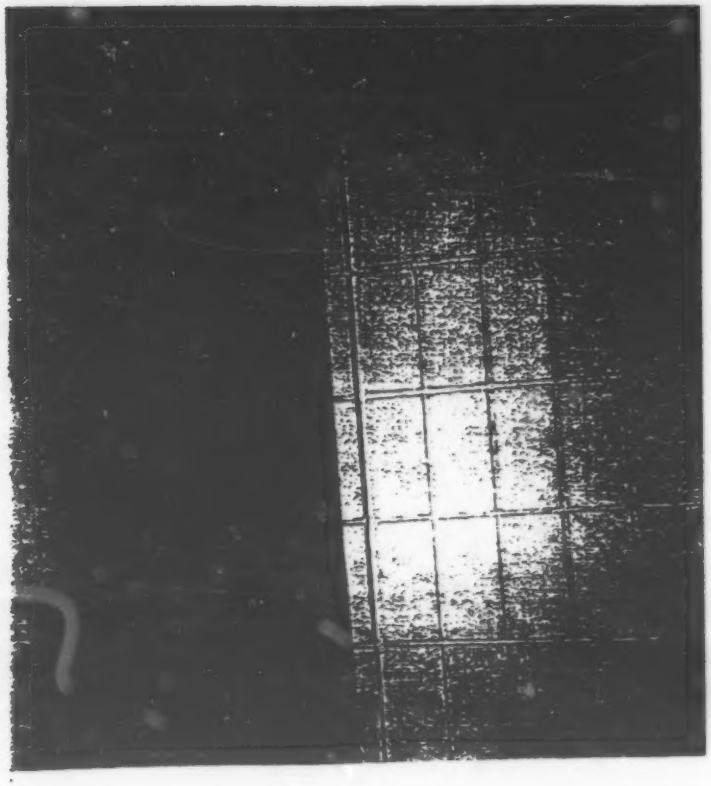
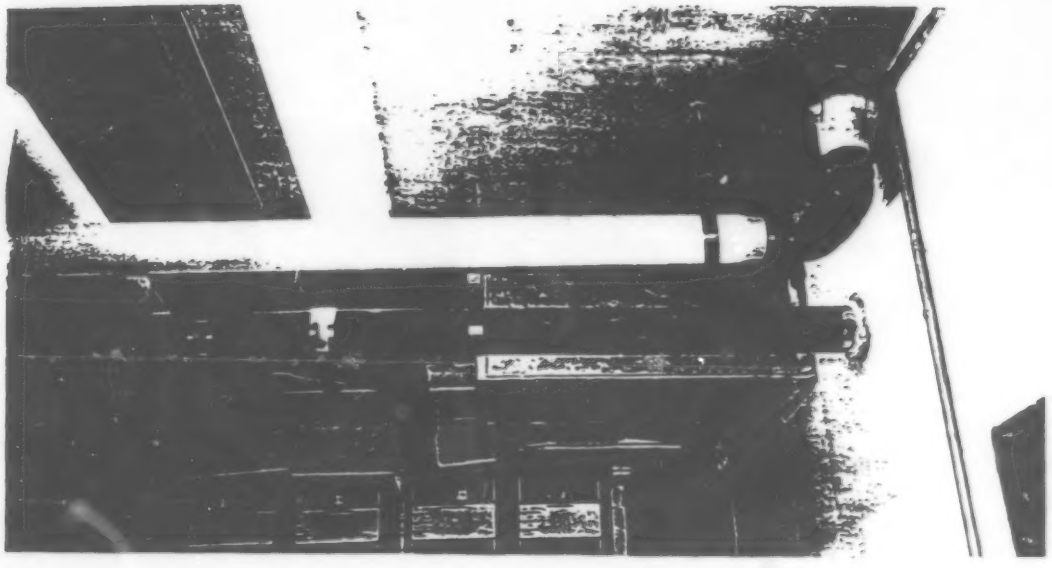


Photo #23 Settlement in building has resulted in a crackin the former firewall

Photo #24 Lagging on pipes may contain asbestos



VANDERHOOF FIRE DEPT.
Box 900 Vanderhoof B.C.
V0J 3A0

Office of the Fire Chief.

Appendix 6b

June 3, 1999

Omineca Lodge
Bag 500
Vanderhoof, BC
V0J 3A0

Attention: Carol Henrotte, Director of Care

RE: Fire Safety issues at Omineca Lodge

1. Hallways are too narrow to safely allow wheel chairs to pass. The building was not built to accommodate wheel chairs.
2. Walkers complicate the traffic flow.
3. Use of wheel chairs on the second floor IS A NON-COMPLIANCE OF THE B.C. FIRE CODE.
4. The top of the stairwell cannot be blocked off to prevent wheelchairs from falling.
5. Elevator would have restricted use in the event of a fire.
6. Reduction of night staff is a concern to the fire department in the event of an emergency. There could be serious complications in the safety of the residents, staff and emergency personnel.

For your information.

Yours truly,

James J Hurtado

Jim Hurtado
Fire Chief

JH/pw

Northern Interior Regional Health Board

Community Care Facility Licensing

Northern Interior Health Unit
1600 3rd Avenue, 4th floor
Prince George BC V2L 3G6
Telephone: (250) 565-8644
Fax (250) 565-8652

BRANCH OFFICES
Burns Lake 692-3171 ..... McBride 569-3765 ..... Vanderhoof 567-6430 ..... Mackenzie 997-6011
Fort St James 996-7178 ..... Fraser Lake 699-8980 Valemount 566-9144

June 7, 1999

Appendix 6c

Mr. Elio Azzara
Regional Director of Planning
Northern Interior Regional Health Board
2000 – 15th Avenue
Prince George, BC

Dear Mr. Azzara:

Thank you for your request for information regarding Omineca Lodge in Vanderhoof, BC. Omineca Lodge became licensed in 1979, and has been used continuously as a community care facility since that time. The facility has a licensed capacity of 35 Intermediate Care residents.

This facility is a 2 storey structure with the residents being cared for on both levels. Consequently, increasing levels of care in a two storey facility could jeopardize health and safety of residents in care for the following reasons:
(Community Care Facility Act Section 8(c))

- Although priority for the first floor is given to the wheel chair residents, the majority of the residents require assistance with ambulating. As the residents continue to age, and their overall needs continue to increase, the facility is forced to accommodate high need residents on the second level. Staffing does not allow for constant supervision of these residents.
- In most cases, the residents accommodated on the second floor are unable to use the stairs. This is an extreme hazard in situations where an emergency evacuation may be required and the elevator is not operational.
- On three occasions in 1998 the Licensing Department received 3 Serious Incident Reports because the elevator malfunctioned. Potential injury to resident was avoided only because a staff member happened to be there.
- The majority of the residents have some form of dementia. This can pose a hazard with using the stairwell in any situation where the resident is alone.
- The majority of the residents have poor eyesight leaving them at risk for injury when using the stairwells.

The facility does not admit extended care residents but should a resident become extended care while living in the lodge, consideration is given to allow the resident to age in place. Final approval of this comes from the Medical Health Officer if she is of the opinion that the placement is safe and it does not jeopardize the health and safety of any client in care.

- The facility is experiencing difficulty with this because if the approval is not granted, there are few options if the appropriate bed is not available at the local hospital. If there is no ava lability and the client remains at the facility without approval, they are then in contravention of **Section 4(5)(a)(i)(iii) which states:**

> **"The licensee shall not**
>
> **(a) provide a service**
>
> **(i) of a type other than that specified on the licence except where, in the opinion of the medical health officer, retention or temporary placement of a person in the facility is in the best interests of the person.**
>
> **(iii) to a resident confined to a wheelchair, unless the room, bathroom and dining room facilities assigned to the person have been specifically designed or modified to accommodate a person in a wheelchair,..."**

Currently, there is no vented smoking room for the residents. It is unsafe and unreasonable to expect these residents to go outside in our northern climate. These residents also require some form of supervision. At present, staff, visitors, and non-smoking clients are constantly being exposed to second hand smoke.

In reviewing the Serious Incident Reports from Omineca Lodge the following concerns are noted:

- Several falls have occurred while toileting the resident, or while the resident was using the toilet on their own.
- Several falls have occurred on the various stairwells.
- 3 reports were received due to a malfunctioning elevator.
- Several residents have gone missing or AWOL because the provisions for the "wandering" client who may have some form of dementia is not suitable.

I have discussed the concern regarding Emergency Prepardness with the Director of Care. At this time, there is no emergency back up generator or other provision in the event of power or gas disruption. This is an extremely hazardous situation.

In August of 1998 it was noted during an inspection that the facility's internal temperature was extremely hot and uncomfortable indicating that the heating/ventilation system is inadequate. This is a health hazard for both staff and residents.

In addition to the above stated health and safety concerns the facility does not meet the following regulations:

Section 5(16)(b) states:

"The licensee shall provide the following appropriately furnished and equipped rooms when offering intermediate care:

(b) a centrally located staff workroom on each floor which has a view of the entrances, exits and corridors;"

This regulation is not being met, in particular, on the second level.

Section 5(2)

"The medical health officer may approve plans submitted by an applicant or licensee for new construction or renovations of a facility which comply with with the *British Columbia Building Code*....."

The facility does not comply with the BC Building Code, specifically in regards to wheelchair accessibility.

Section 5(12))

"The licensee shall provide a readily accessible outside activity area of not less than 1.4 meters squared for each person in a residence which shall include a surfaced patio with comfortable and safe seating for not less than 25% of the residents"

This area is currently being used as a staff smoking area.

Section 5(13)

"A reasonable portion of the patio shall be sheltered from the sun and prevailing wind"

The facility does not meet this standard.

Section 5(3)(k)

"resident bedrooms shall have an entrance door not less that 830mm in width"

The facility does not meet this standard.

Section 5(6)(c)

"The licensee shall provide

(c) washbasin and toilet facilities adjacent to the dining, lounge and recreational areas which shall be accessible by wheelchair"

The facility does not meet this standard.

Section 5(3)(l)

"each resident bedroom must have sufficient natural or artificial illumination to provide

(i) general room illumination to meet the needs and preferences of each resident, with a minimum capacity of 220 lux,

(ii) task or reading illumination to meet the needs and preferences of each resident, with a minimum capacity of 420 lux, and

(iii) 320 lux of bathroom illumination;"

The facility does not meet this standard.

0025

Please contact at 565-6644 if you have any questions or concerns in regards to the above information.

Sincerely,

T. Pawluk

Tracey Pawluk, RN
Licensing Officer
Community Care Licensing

A Multi-Level Care Facility

Why Our Community Needs One

Presentation to Nechako Valley CAC
October 20, 1998
Vanderhoof, British Columbia

Omineca Lodge was opened in 1979 as an intermediate care unit. At that time, residents were admitted with personal care level IC1 through IC3. There was only one resident who required the use of a wheelchair and many residents were able to participate actively in their personal care. Omineca Lodge is a 2 ½ storey building the length of a city block with 12 outside entrances. The east wing houses intermediate care residents on two floors (for a total of 35 residents), the west wing houses 18 "self-care" apartments. Nursing care is not provided for the self care residents although each apartment is equipped with a call bell in the bathroom and one in the main part of the apartment. The only physical separation between the two areas of the building is by fire doors.

In 1998, the majority of the residents in Omineca Lodge are at the IC3 level, 70-75% of our residents have some form of dementia ranging from Alzheimer's Disease to Multi-infarct Dementia (all in degrees of severity). Nursing care of the present residents focuses heavily on psychogeriatric care and the present building is no longer adequate to meet the needs and safety of these residents.

The Omineca Lodge does not admit extended care (EC) residents but should a resident become EC while living in the lodge, consideration is given to keeping these residents in the facility depending on th circumstances (spouse living at the Lodge, benefits from recreation programs). There have been upwards of 4 EC residents living in the Lodge with no increase in the number of staff to reflect this.

The staff at Omineca Lodge would like to describe some of the concerns surrounding the inadequacies of the physical building, staffing and support services.

1. **Staffing:**

Presently the Omineca Lodge is staffed by the following:

Monday-Friday Days:	1 RN(8hours), 2 care aides (7.5 h), 1 Director of Care (7.2h)
	1 bath/care aide (4h)
	1 housekeeper (7.2 h)
	1 maintenance (7.2h)
	1 laundry (7.2h)
	1 rec. therapist (7.5h)
	2 kitchen (7.2h)
Monday-Sunday Eve:	1 RN
	2 care aides
Monday-Sun. Nights:	1 RN
	1 care aide
Saturday-Sun Days:	1 RN
	2 care aides
	2 kitchen staff

Increased nursing staff is required to adequately manage residents with behaviour problems, chronic illness, dementia and psychosocial concerns. Staff spend the majority of their time on the first floor, leaving second floor residents unsupervised and with minimal staff contact. Inability to meet nursing standards does occur due to the high demands of 35 residents and only one nurse to priorize, assess and intervene when problems occur. We are no longer able to "reserve" downstairs rooms for residents with problems such as wandering, aggression, frailty etc. These are the people requiring the most supervision from the staff and some are not getting it. Many residents are unable to die at the Omineca Lodge merely due to the fact that we do not have the ability to call in staff to stay with them and if they live in a double room the fact that there is no privacy for the resident and their family is also an issue. As we are caring for a high percentage of residents with psychogeriatric conditions such as Alzheimer's Disease and related dementias we are finding that we do not have the adequate time or staffing to adequately assess, plan, implement and evaluate the appropriate methods of treatment for these people.

We do not have laundry staff on weekends or statutory holidays despite the fact that the amount of laundry does not change. We have many residents who are incontinent of bladder and bowel on a routine basis (sometimes more than once per 8 hours) This amounts to a lot of laundry that can be left for two or three days. When a statutory holiday occurs, a laundry person is called in for work on a day before the holiday to catch up on the amount of laundry that needs to be done.

There is only one housekeeper for the building (with the exception of heavy housekeeping which is done by maintenance staff). There is no housekeeping on statutory holidays which means nursing staff is emptying garbage cans, mopping floors and sweeping on top of the already heavy workload of looking after residents. This minimal housekeeping needs to be done at all times just for safety and because it is our resident's home and should not be left unclean.

There is no bath person on weekends or statutory holidays so baths are being done by the staff on duty at the time and with the present demands of residents this can sometimes be unsafe for those left out on the floor in addition to being an extra workload. If the baths are left undone over the long weekend then the 4 hour bath person is unable to catch up to the backlog of baths.

Nursing care staff are having to intervene far more often with self care residents who require more assistance than what they are getting from family or homemakers. At present it is our opinion that possibly one half of the residents on self care would be assessed to a level of care that would be offered by our staff. One resident has been assessed at extended care level. She is aware of the risks that involves by staying on self care and has refused to be waitlisted for a facility.

We do not have the ability to call in extra care staff (RN or care aide) without the permission of Continuing Care in Prince George (using Added Care or Psychogeriatric Added Care) which is given as 4 hours per day over 5 days and needs to relate to a particular resident. As of early September, there are no more added care hours(using either program) for this region until next April.

ELEVATOR

The elevator at the Omineca Lodge is continually under repairs for problems relating to slow movement, doors not opening or closing properly (or not at all), and the elevator carriage opening and being several inches (up to 12) below the level of the floor of the Lodge.

This is an extreme safety hazard for the staff and residents of Omineca Lodge. We have residents on the second floor who cannot use the stairs and the elevator is their only means of getting to the main floor. Residents also have poor eyesight (related to disease or the aging process) and cannot see that the floor may be of two levels. This leaves them at great risk for falling and fracturing bones. There have been several times in the past two months that the elevator has had to be shut down as it was not working in a safe enough manner for the staff and residents to use. Problems with the elevator are being documented for reference.There are two incidents of non-serious injuries sustained by residents in the past two months as a result of elevator malfunction.

EQUIPMENT/RENOVATIONS

If the Omineca Lodge is to remain functioning as it is today then renovations are going to be needed to support the staff in delivering the care deserving of the residents who live there. Some of these renovations are quite simple but very effective.

1. We have been given verbal permission from Licensing Officer, Tracy Pollack for the removal of bathroom walls in resident's rooms (to be replaced by sliding accordian curtain or draw curtain). This is necessary in order for some residents to even be able to use their bathroom at all. We have used commodes at bedsides as it was not safe for the resident and staff to get into the bathroom due to the small size and small doorway. These doors and bathrooms are not wheelchair accessible nor can they be accessed by the mechanical lift if somebody falls in the bathroom. The go ahead for renovations of this sort has not been given.

2.There are no wheelchair accessible doors at the Omineca Lodge so residents need assistance to get in and out of the doors if using a wheelchair.

3.Because we are an intermediate care facility there is no funding for equipment such as wheelchairs. Residents must purchase their own if they are going to use one. The wheelchairs that we do have, which have been donated, are in ill repair (cost to repair it would be more than what that the chair is worth) and some are no longer safe to use. We require more mechanical lifts which we can actually use in our rooms. We own one which cannot be used in bathrooms nor in some of the bedrooms due to space limitations.

4. The century tub that we use is no longer appropriate for the types of residents we care for. Residents with dementia often have a fear of water and to be put in a chair, raised to the ceiling and lowered into a tub of water is very frightful. The tub requires that the resident lift their legs up and over the edge which is difficult to do if they are arthritic. The chair, at it's highest point, is only inches from the heat lamp which requires that the bath person place a towel on some resident's heads so they don't get overheated from the lamp. This same tub is starting to show cracks in the lining and has been breaking down on occasion in the past couple of months.

5. A smoking room is necessary for our residents who smoke in both upstairs and downstairs public lobbies. Non smoking residents, staff and visitors are constantly exposed to second hand smoke which is a health hazard. This room must be vented to the outside and located in a place that is very visible to staff as some residents require some form of supervision while smoking. WCB requires that

the smoking room be built.

Environmental Concerns.

A. **Heating/Ventilation**: there is essentially no ventilation at all in the building. No way to regulate the heat per room so some are very hot and others are very cold. In the winter, several rooms require that heaters be put in to keep them warm. Cool air blows up in vents in the dining room right underneath where people sit and they find it very cold (have to wear heavy sweaters or blanket over their shoulders at mealtimes). We have to put a heater in the elevator room in the winter in order to keep it running properly.

B. **Invasive Systems**: 11 doors in the facility are fitted with "wanderguard" alarms that are activated when a resident wearing a special bracelet stands near the door. The alarms also go off if the doors are open and there is a breeze coming in the building. The purpose of the alarm is to notify staff if residents, who are at risk for wandering, are attempting to leave the building. A staff member must check the door that is alarming and make sure the resident is safe. During the winter this is not such a problem, but during summer months this alarm is going constantly, sometimes three doors at a time. The sound of the alarm is extremely disruptive, increases agitation levels of those residents with dementia and causes steady interruption to the work of staff members who must stop what they are doing to check the doors. We have been told for the past three years that we would be getting some sort of new system that would not involve the alarm however this has not come to pass. We do understand, however that administration is working on a revised alarm system that would be much less expensive than what was originally planned as a change to what we have now.

The call bells in the Omineca Lodge are another extremely disruptive noise which occurs very frequently throughout the day. We presently have no way of turning down the sound so that it is not deafening at the desk but at the same time can be heard down the hall. If this buzzer goes off when a person is speaking on the phone you can hardly hear the person you are speaking to. This sound also increases the agitation of the residents; one resident attempts to shut them off and another will stand at the desk and imitate the sound of the buzzers. The sound has been adjusted somewhat but cannot be heard from within the tub room and is still not audible on the second floor of the Lodge.

C. **Lighting:** is very inadequate in most areas of the Omineca Lodge. This is a safety concern for our residents because they are unable to distinguish changes in floor patterning (ie: from rug to linoleum) and this is a hazard for falls. Common areas such as the front lobbies and living rooms are so poorly light that in the winter time it is difficult for some residents to see much at all. Many residents are unable to tell whether it is day, night or dusk due to the lighting in the Lodge. This adds to their confusion and disorientation.

Lighting in resident rooms is poor. In a double room, there is only one ceiling light . It is an all or none situation, either both residents are in the dark or both in the light. There are no overbed lights or nightlights. Nursing staff often have to examine resident's skin conditions with flashlights in order to do a proper assessment; this is especially so in the resident's bathrooms where lighting is extremely inadequate.

D. **Resident rooms**: In addition to lighting, privacy is a problem in our double rooms. We are constantly dealing with unhappy residents and families surrounding the issues of roommate incompatibility and privacy. We have had residents assault each other or damage property and this is not a good situation. Because of the large number of residents with dementia they require private rooms and this is not always possible.

There is a lack of space in which to work in our residents rooms, in particular the bathrooms. We are unable to get a mechanical lift in the bathrooms should anyone fall in there. In the double rooms it is nearly impossible to use a lift to get people in and out of beds therefore we don't use it. Bathrooms in single rooms are not wheelchair accessible and staff have great difficulty maneouvering people in and out of these rooms. Toilets are positioned so that staff are not able to be on both sides of the toilet to assist someone on and off if needed. Toilets should be placed at an angle in the bathroom.

Storage space in bathrooms is inadequate. We are storing stuff on the backs of toilets as it is easy to reach however this is not the most hygenic place to store personal items.

E. **Kitchen**: the present kitchen facilities at the Lodge are no longer equipped to deal with the duties of the kitchen staff. Equipment is breaking down on a frequent basis as most of it is in the twenty year old range. The dishwasher is often leaking leaving a trail of water on the floor that is a great slipping hazard for the staff. Food preparation area is extremely small, there is not adequate office space for the staff and the dietician to carry out their administrative type work. Kitchen staff not only prepare meals for the 35 residents on the intermediate care side of the Lodge but are preparing meals for residents of self care as well. Heating and ventilation in the kitchen is very poor. In the winter time, the cold air blows through so much that kitchen staff often wear their heavy sweaters or jackets in order to keep warm. In the summer time it is extremely hot in the kitchen. There is also the ongoing problem of the sewer backing up into the kitchen which is a health concern.

F. **Dining Room**: is severely overcrowded. Doorway to the back patio is often blocked by walkers and/or wheelchairs which is a fire hazard. We have 11 residents who are using wheelchairs all the time for transportation with an additional 5 residents using wheelchairs on an occasional basis. 3 residents use walkers on a full time basis. This amounts to just over one half of the residents of Omineca Lodge requiring mechanical assistance for ambulation. The dining room was not set up to contain this many residents with wheelchairs and walkers therefore it is often the case that staff have to squeeze between or climb over chairs, or residents are pushing each other out of the way trying to sit at their table. In addition, this situation poses a hazard for evacuating the area or getting to someone with a stretcher in the case of emergency.

The flooring in the dining room needs replacing as it is extremely old, cracking, and looks dirty all the time. It does nothing to add to the pleasant dining experience which is what we try to achieve.

G.**Landscaping** : the present "wandering area" for residents is extremely non-functional. There is absolutely nothing in that area that entices them to go outside and enjoy themselves. It is nothing more than a sidewalk through a piece of lawn. The sidewalk is not even and residents in wheelchairs frequently go off the side and fall over onto the lawn. There is no area suitable for the residents to sit for

any length of time without being in the full sun. We would like to see raised flower and vegetable beds for residents as they are not able to get on their hands and knees to do any gardening.

The Lodge is very close to the river and this is a hazard for wandering residents. Staff are not able to keep track of everybody all the time and there was one occasion where a resident came very close to going over the river bank.

H. **Activity Facilities**: the activity room at the Omineca Lodge is located in the basement therefore it is not utilized to it's potential. Most residents are unable to go to this room without assistance so there is no use of this room by residents unless there is a scheduled activity. Activity facilities need to be on the main floor where they can be accessed by residents at all times. Our recreation staff are very active with our residents and provide excellent programming. Having facilities that are accessible to all residents would certainly enhance this aspect of resident care.

Servicing Concerns

A. **Resident Assessments**: These are to be done by the Long Term Care Assessor from Continuing Care in Prince George however due to the huge case loads (one assessor can have up to 1200 people)and the distance for traveling to outlying areas, assessments are not being done at a pace that keeps up with the changes in residents conditions. Consequently, our director of care is doing a lot of the assessments in order to reflect the levels that our residents are actually at. Recently, we found that an assessment we had asked for in 1996 still had not been done. What is needed is a long term care assessor for our area alone.

B. **Added Care/Psychogeriatric Care Hours**: these are blocks of time (4 hours a day for a maximum of 5 days) which can be provided to care for a resident requiring more time and care than normally given by the staff at the Lodge. For example: if a resident has the flu but is not ill enough to go to hospital (or the doctor won't admit them to hospital) a care aide or RN can come in for a 4 hour slot of time for a few days and help this person. Approval for use of these hours has to come from Continuing Care in Prince George; our own RN in charge does not have the authority to call in extra staff if the situation warrants it. At this time, there are no more hours available in either of these programs until the next fiscal year which is April 1, 1999.

This situation is not acceptable. Our residents need extra care when they need it, not when it is convenient to someone else or when the budget says they can have it. We like to care for our residents at the Lodge, if at all possible, as this is their home and it is far cheaper to care for them there as opposed to the hospital. Our nurses need to be given the authority to call in extra staff as they see fit in order to provide safe and quality care to the residents of Omineca Lodge.

C. **Resident Placement**: better access to special care beds is a must in this region. The present number of special care beds is not enough for the amount of residents who require them. In addition, the requirements to get into the special care unit are preventing some residents from going there even though they are unable to live in their present facility.

What is really needed is an "acute" bed for assessment or respite for special care residents. For example: a resident who is experiencing severe behavior problems as a result of dementia or mult-

infarct may need to have major changes in their medications (either coming off medications altogether, or increase/decrease in dosages). The problem with this is that a facility such as Omineca Lodge is no place for such a situation. The staffing is not adequate and the facility is not set up to deal with a resident who needs such supervision. As a result, we try to deal with behavior problems as best we can even though residents and staff can be victims of assault, increased agitation and aggression occurs in more residents and the whole atmosphere has been disruptive. A special care unit must be included in a new facility should there be one built in Vanderhoof. The need for such a unit is indeed great considering the number of residents we have with severe dementia and behavior problems, not to mention those in the community who might benefit from the services provided in this special area.

D. **Workload Assessment Tools**: we are using a very good one which was recommended by a private consultant hired by Victoria to tour facilities such as ours. However, this tool is not used by anybody else and Long Term Care in Prince George won't even consider it as being valid. This tool reflects the amount of time (in minutes) that is required by a resident over a 24 hour period. Points are given for the amount of time, tallied up and the end result is finding out what level of care a resident is at. Some of our residents exceed the point limit by a thousand points indicating they require a very large amount of nursing care because of psychogeriatric conditions and environmental concerns such as resident mix (cognitively impaired with cognitively well) or noise level (buzzers and wanderguard alarms that cause much agitation).

Extended Care

Presently, the Omineca Lodge has 3 extended care residents. Special circumstances allow that extended care residents remain at the Omineca Lodge provided the staff are able to care for them. We do not get any extra staff as a result of having these residents remain with us. If they become extended care and it is decided to wait list them for another facility, the closest to home is the extended care beds at St. John Hospital in Vanderhoof. Unfortunately, this is not the place for extended care residents to be. The hospital environment is not even close to a "home" environment for these people and these six beds are not staffed separately from the acute care aspect of the hospital. Therefore, in the cases of emergencies, maternity cases or extra busy surgical floor these residents simply do not get the care that they require. This is not a reflection on the staff at the hospital; they work there because hospital care is what they excel at and enjoy. If they had wanted to work with the extended care population they would already be at the Omineca Lodge.

These residents do receive a small amount of recreation therapy provided by our recreation staff member otherwise their environment is strictly "hospital" complete with the sounds, smells and activities of a hospital. Essentially, the quality of life received by these residents is poor.

Self-Care Tenants At Omineca Lodge

18 tenants reside in the Self Care section of the Lodge. As mentioned early, Omineca Lodge does not provide staff to care for these people however we are intervening there on an increasing basis without the knowledge about the resident's condition. Residents are sent home from hospital (ie: eye

8/9

surgery) and require frequent treatments throughout the day. The home care nurse cannot be at the Lodge every 4 hours to give the person eye drops so this falls on the nurse working on the intermediate care side. We are called to help people on and off toilets, pick them off the floor, do dressings,and open jars and cans. These residents do not understand that they do not come ahead of the intermediate care residents in terms of service from our staff. They are also not accepting of the problems experienced by our confused residents and often treat them with disrespect.

Unfortunately families and residents of self care simply do not make the connection that the staff and services of the Lodge are for the Intermediate care residents. The mere fact that self care rooms were equipped with emergency call bells that ring at the nursing station gives the expectation that help is only seconds away.

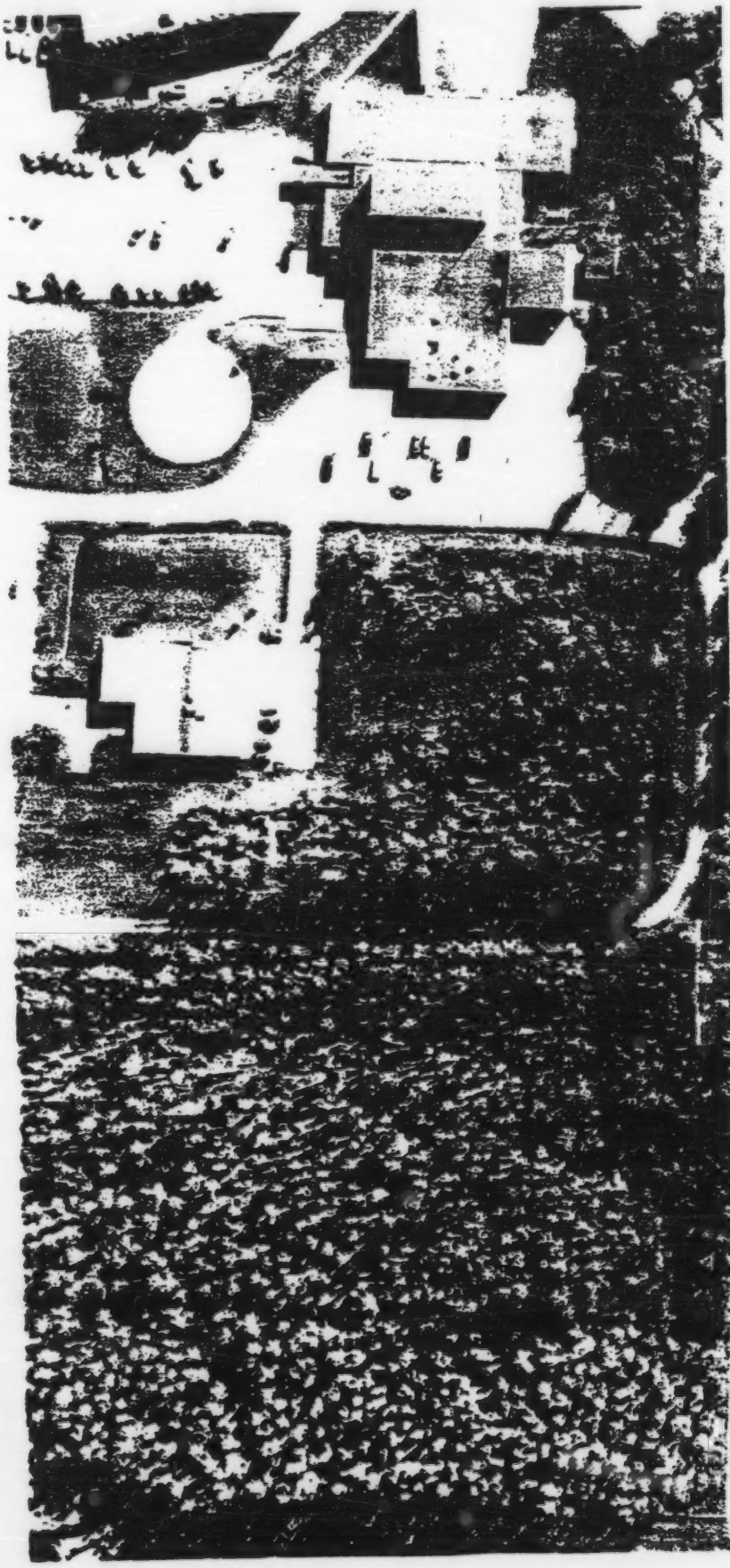
Presently there is one self care resident who is unable to get out of bed on her own. This was unknown to us until her homemaker told us that this person was worried about the fire alarms as she could not get out of her room if there was a fire. This resident is at extended care level so can't be admitted to our side of the Lodge. She is mentally well and it would be extremely detrimental for her to end up in the extended care section of the hospital.

Recommendation

The residents and staff at Omineca Lodge are more than ready for a new facility. We believe that renovating the present building to a point that would meet the needs of the residents and staff and ensure a safe living/working environment would be more costly and disruptive than it would be to build a new facility. If a new facility is not possible then we must undertake renovations of some kind just to make the building safer to live and work in.

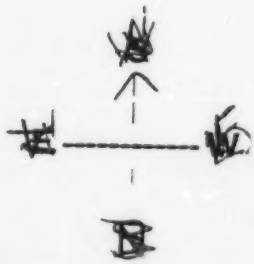
We believe the community is very lucky to have a group of dedicated, caring and compassionate staff that believe in advocating for those who are unable to speak for themselves. We wish to take a very active role in the planning of a new facility should that be decided upon. It only makes sense that those people that actually work in the building would have the ideas for planning a new one.

We look forward to working with members of the Nechako Valley CAC and the Northern Interior Regional Health Board in the discussions and planning of a new facility as we understand from our administrator that this issue is definitely a priority for these committees.

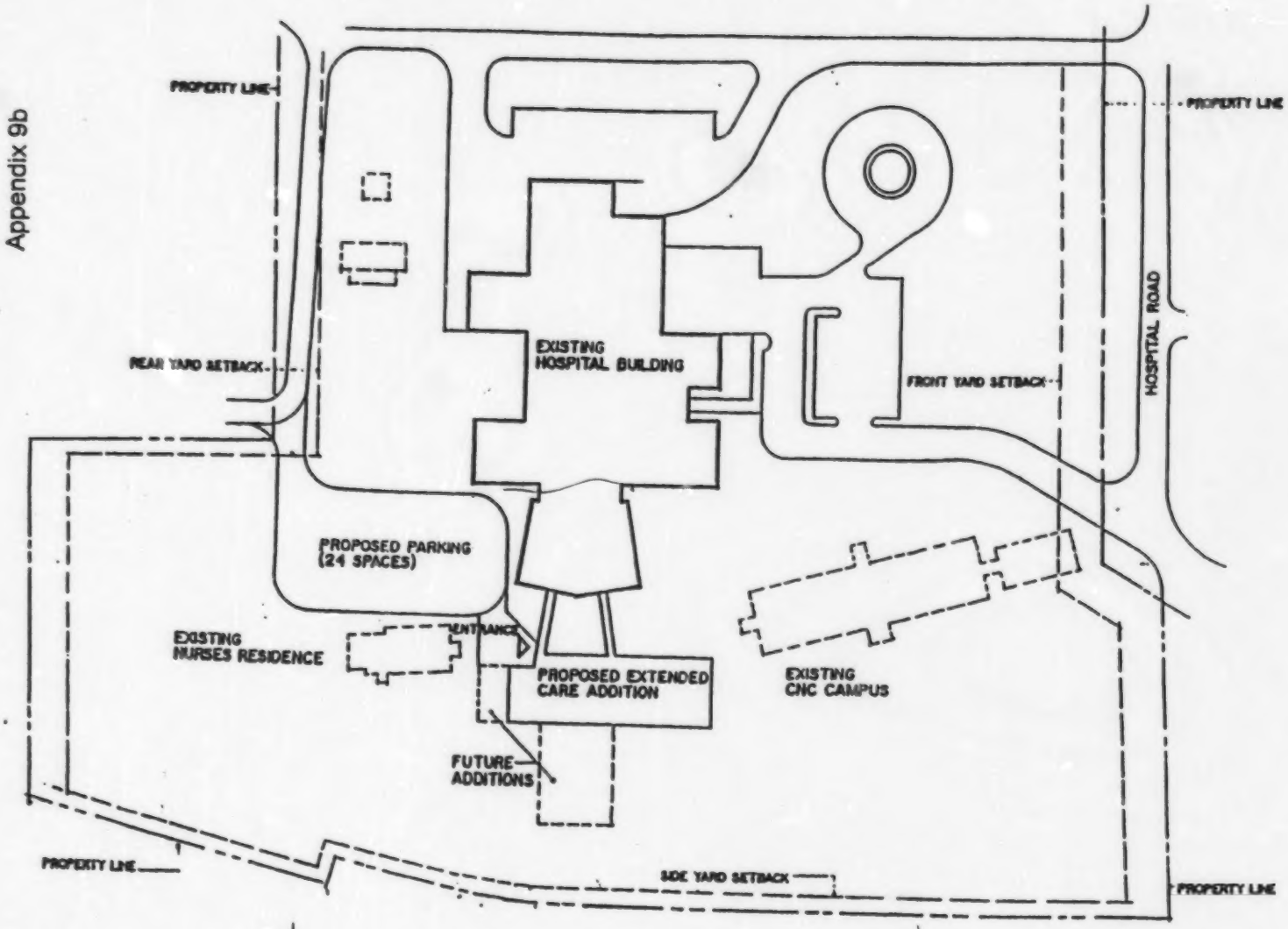


AERIAL VIEW OF
ST. JOHN HOSPITAL SITE

FROM TOP TO BOTTOM
- CNC College
- St. John Hospital
- Health Unit
- Treed area part of hospital property



Appendix 9b



EXTENDED CARE ADDITION ALTERNATE 'D'

0 40 80 120 160 200 FEET

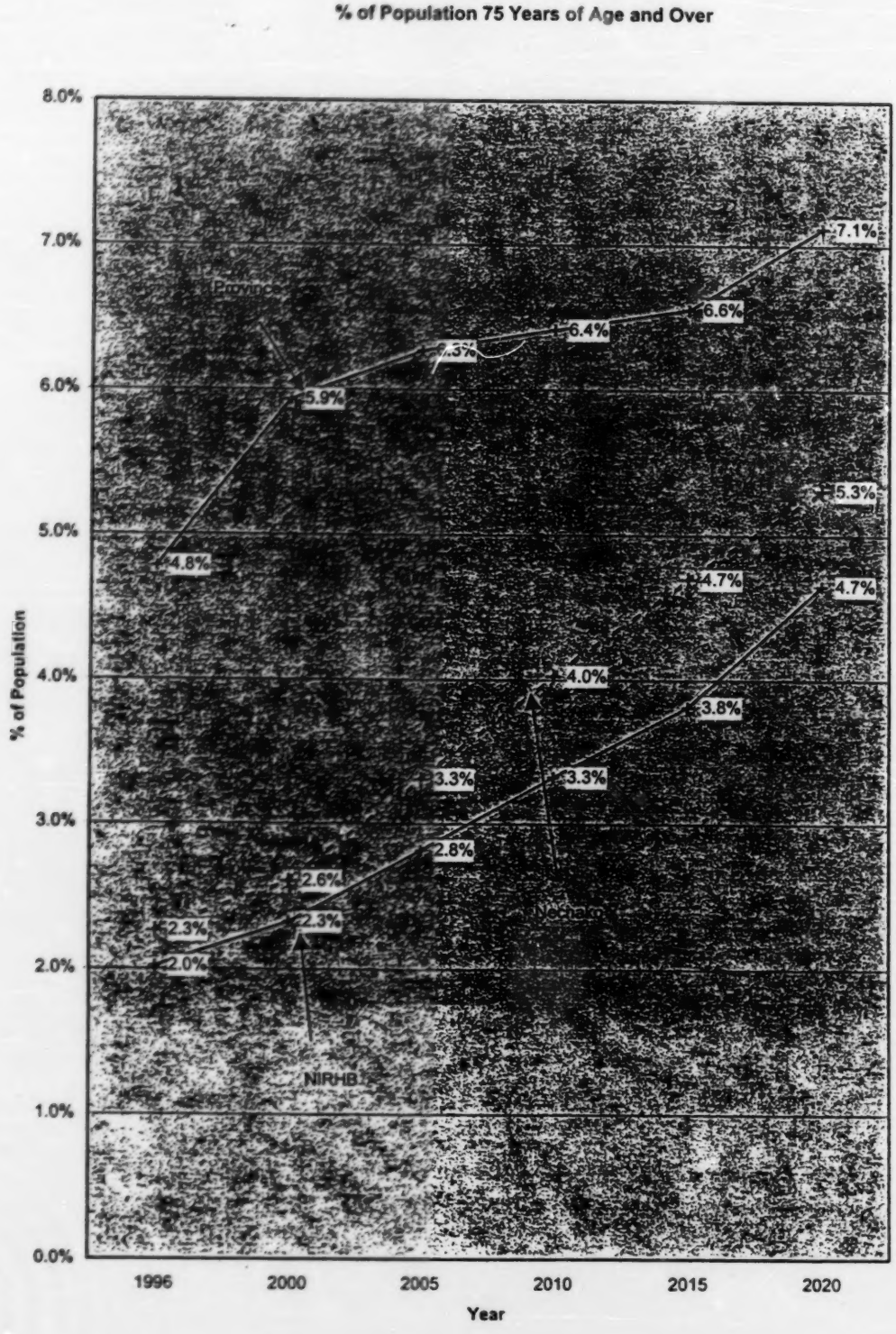
N

ST JOHN HOSPITAL
VANDERHOOF, B.C.

APPENDIX B

POPULATION DEMOGRAPHICS NECHAKO AND NORTHERN INTERIOR REGIONAL HEALTH BOARD

Appendix 2a - Graph



Appendix 2a
Chart1996-2020

2001/03/05

NIRHB

Appendix 2a - Table

	1996	2000	2005	2010	2015	2020
Nechako #56						
0 to 74	17399	18235	19189	19798	20438	21153
% pop 0-74	97.7%	97.4%	96.7%	96.0%	95.3%	94.7%
75 to 79	195	235	308	375	428	488
80 to 84	129	133	169	227	285	328
85 and over	79	120	179	228	294	370
Nechako	2.3%	2.6%	3.3%	4.0%	4.7%	5.3%
Total	17802	18723	19845	20628	21445	22339
Province of BC						
0 to 74	3696423	3855585	4182467	4515952	4848597	5143981
% pop 0-74	95.2%	94.1%	93.7%	93.6%	93.4%	92.9%
75 to 79	88507	111115	116380	123774	136350	169658
80 to 84	56304	71148	87505	92104	98268	109039
85 and over	40809	60778	75806	93546	105510	115504
Province	4.8%	5.9%	6.3%	6.4%	6.6%	7.1%
Total	3882043	4098626	4462158	4825376	5188725	5538182
NIRHB						
0 to 74	126506	131414	138829	146162	153317	158621
% pop 0-74	98.0%	97.7%	97.2%	96.7%	96.2%	95.3%
75 to 79	1311	1561	1876	2299	2705	3693
80 to 84	806	880	1160	1411	1743	2057
85 and over	489	687	991	1313	1628	1989
NIRHB	2.0%	2.3%	2.8%	3.3%	3.8%	4.7%
Total	129112	134542	142856	151185	159393	166360

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2000

Appendix 2b

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Health Region 15 Northern Interior

Age Group	Females		Males		Total	
< 1	838	(1.3%)	884	(1.3%)	1,722	(1.3%)
1 - 4	3,622	(5.6%)	3,697	(5.3%)	7,319	(5.4%)
5 - 9	5,120	(7.8%)	5,234	(7.6%)	10,354	(7.7%)
10 - 14	5,077	(7.8%)	5,591	(8.1%)	10,668	(7.9%)
15 - 19	5,149	(7.9%)	5,685	(8.2%)	10,834	(8.1%)
20 - 24	4,829	(7.4%)	5,108	(7.4%)	9,937	(7.4%)
25 - 29	4,901	(7.5%)	4,905	(7.1%)	9,806	(7.3%)
30 - 34	5,224	(8.0%)	5,429	(7.8%)	10,653	(7.9%)
35 - 39	5,963	(9.1%)	6,265	(9.0%)	12,228	(9.1%)
40 - 44	5,770	(8.8%)	6,169	(8.9%)	11,939	(8.9%)
45 - 49	5,127	(7.9%)	5,477	(7.9%)	10,604	(7.9%)
50 - 54	4,190	(6.4%)	4,419	(6.4%)	8,609	(6.4%)
55 - 59	2,929	(4.5%)	3,408	(4.9%)	6,337	(4.7%)
60 - 64	1,968	(3.0%)	2,544	(3.7%)	4,512	(3.4%)
65 - 69	1,550	(2.4%)	1,909	(2.8%)	3,459	(2.6%)
70 - 74	1,183	(1.8%)	1,250	(1.8%)	2,433	(1.8%)
75 - 79	852	(1.3%)	709	(1.0%)	1,561	(1.2%)
80 - 84	512	(0.8%)	368	(0.5%)	880	(0.7%)
85 +	444	(0.7%)	243	(0.4%)	687	(0.5%)
TOTALS:	65,248	(100.0%)	69,294	(100.0%)	134,542	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2005

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Health Region 15 Northern Interior

Age Group	Females		Males		Total	
< 1	867	(1.2%)	912	(1.2%)	1,779	(1.2%)
1 - 4	3,533	(5.1%)	3,691	(5.0%)	7,224	(5.1%)
5 - 9	4,677	(6.7%)	4,768	(6.5%)	9,445	(6.6%)
10 - 14	5,177	(7.4%)	5,325	(7.3%)	10,502	(7.4%)
15 - 19	5,007	(7.2%)	5,598	(7.6%)	10,605	(7.4%)
20 - 24	5,180	(7.4%)	5,667	(7.7%)	10,847	(7.6%)
25 - 29	5,233	(7.5%)	5,369	(7.3%)	10,602	(7.4%)
30 - 34	5,428	(7.8%)	5,343	(7.3%)	10,771	(7.5%)
35 - 39	5,514	(7.9%)	5,773	(7.9%)	11,287	(7.9%)
40 - 44	6,041	(8.7%)	6,364	(8.7%)	12,405	(8.7%)
45 - 49	5,762	(8.3%)	6,138	(8.4%)	11,900	(8.3%)
50 - 54	5,024	(7.2%)	5,335	(7.3%)	10,359	(7.3%)
55 - 59	3,996	(5.7%)	4,255	(5.8%)	8,251	(5.8%)
60 - 64	2,727	(3.9%)	3,183	(4.3%)	5,910	(4.1%)
65 - 69	1,758	(2.5%)	2,241	(3.1%)	3,999	(2.8%)
70 - 74	1,389	(2.0%)	1,554	(2.1%)	2,943	(2.1%)
75 - 79	974	(1.4%)	902	(1.2%)	1,876	(1.3%)
80 - 84	672	(1.0%)	488	(0.7%)	1,160	(0.8%)
85 +	661	(0.9%)	330	(0.5%)	991	(0.7%)
TOTALS:	69,620	(100.0%)	73,236	(100.0%)	142,856	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2010

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Health Region 15 Northern Interior

Age Group	Females		Males		Total	
< 1	898	(1.2%)	943	(1.2%)	1,841	(1.2%)
1 - 4	3,653	(4.9%)	3,817	(4.9%)	7,470	(4.9%)
5 - 9	4,650	(6.3%)	4,822	(6.2%)	9,472	(6.3%)
10 - 14	4,750	(6.4%)	4,873	(6.3%)	9,623	(6.4%)
15 - 19	5,103	(6.9%)	5,336	(6.9%)	10,439	(6.9%)
20 - 24	5,070	(6.9%)	5,591	(7.2%)	10,661	(7.1%)
25 - 29	5,646	(7.6%)	5,998	(7.8%)	11,644	(7.7%)
30 - 34	5,814	(7.9%)	5,876	(7.6%)	11,690	(7.7%)
35 - 39	5,746	(7.8%)	5,728	(7.4%)	11,474	(7.6%)
40 - 44	5,593	(7.6%)	5,882	(7.6%)	11,475	(7.6%)
45 - 49	6,023	(8.1%)	6,316	(8.2%)	12,339	(8.2%)
50 - 54	5,649	(7.6%)	5,974	(7.7%)	11,623	(7.7%)
55 - 59	4,802	(6.5%)	5,144	(6.7%)	9,946	(6.6%)
60 - 64	3,752	(5.1%)	3,999	(5.2%)	7,751	(5.1%)
65 - 69	2,469	(3.3%)	2,828	(3.7%)	5,297	(3.5%)
70 - 74	1,579	(2.1%)	1,838	(2.4%)	3,417	(2.3%)
75 - 79	1,154	(1.6%)	1,145	(1.5%)	2,299	(1.5%)
80 - 84	780	(1.1%)	631	(0.8%)	1,411	(0.9%)
85 +	875	(1.2%)	438	(0.6%)	1,313	(0.9%)
TOTALS:	74,006	(100.0%)	77,179	(100.0%)	151,185	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2015

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Health Region 15 Northern Interior

Age Group	Females		Males		Total	
< 1	921	(1.2%)	970	(1.2%)	1,891	(1.2%)
1 - 4	3,794	(4.8%)	3,968	(4.9%)	7,762	(4.9%)
5 - 9	4,808	(6.1%)	4,987	(6.2%)	9,795	(6.1%)
10 - 14	4,734	(6.0%)	4,942	(6.1%)	9,676	(6.1%)
15 - 19	4,692	(6.0%)	4,888	(6.0%)	9,580	(6.0%)
20 - 24	5,170	(6.6%)	5,348	(6.6%)	10,518	(6.6%)
25 - 29	5,552	(7.1%)	5,942	(7.3%)	11,494	(7.2%)
30 - 34	6,257	(8.0%)	6,529	(8.1%)	12,786	(8.0%)
35 - 39	6,149	(7.8%)	6,280	(7.8%)	12,429	(7.8%)
40 - 44	5,829	(7.4%)	5,840	(7.2%)	11,669	(7.3%)
45 - 49	5,577	(7.1%)	5,844	(7.2%)	11,421	(7.2%)
50 - 54	5,911	(7.5%)	6,154	(7.6%)	12,065	(7.6%)
55 - 59	5,422	(6.9%)	5,770	(7.1%)	11,192	(7.0%)
60 - 64	4,543	(5.8%)	4,855	(6.0%)	9,398	(5.9%)
65 - 69	3,444	(4.4%)	3,602	(4.4%)	7,046	(4.4%)
70 - 74	2,241	(2.9%)	2,354	(2.9%)	4,595	(2.9%)
75 - 79	1,327	(1.7%)	1,378	(1.7%)	2,705	(1.7%)
80 - 84	935	(1.2%)	808	(1.0%)	1,743	(1.1%)
85 +	1,063	(1.4%)	565	(0.7%)	1,628	(1.0%)
TOTALS:	78,369	(100.0%)	81,024	(100.0%)	159,393	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2020

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Health Region 15 Northern Interior

Age Group	Females		Males		Total	
< 1	914	(1.1%)	960	(1.1%)	1,874	(1.1%)
1 - 4	3,802	(4.6%)	3,979	(4.7%)	7,781	(4.7%)
5 - 9	4,934	(6.0%)	5,128	(6.1%)	10,062	(6.0%)
10 - 14	4,865	(5.9%)	5,081	(6.0%)	9,946	(6.0%)
15 - 19	4,658	(5.7%)	4,949	(5.9%)	9,607	(5.8%)
20 - 24	4,721	(5.7%)	4,870	(5.8%)	9,591	(5.8%)
25 - 29	5,584	(6.8%)	5,637	(6.7%)	11,221	(6.7%)
30 - 34	6,089	(7.4%)	6,388	(7.6%)	12,477	(7.5%)
35 - 39	6,556	(8.0%)	6,860	(8.1%)	13,416	(8.1%)
40 - 44	6,234	(7.6%)	6,376	(7.6%)	12,610	(7.6%)
45 - 49	5,814	(7.1%)	5,815	(6.9%)	11,629	(7.0%)
50 - 54	5,476	(6.7%)	5,701	(6.8%)	11,177	(6.7%)
55 - 59	5,706	(6.9%)	5,966	(7.1%)	11,672	(7.0%)
60 - 64	5,181	(6.3%)	5,488	(6.5%)	10,669	(6.4%)
65 - 69	4,242	(5.2%)	4,429	(5.3%)	8,671	(5.2%)
70 - 74	3,158	(3.8%)	3,060	(3.6%)	6,218	(3.7%)
75 - 79	1,890	(2.3%)	1,803	(2.1%)	3,693	(2.2%)
80 - 84	1,076	(1.3%)	981	(1.2%)	2,057	(1.2%)
85 +	1,254	(1.5%)	735	(0.9%)	1,989	(1.2%)
TOTALS:	82,154	(100.0%)	84,206	(100.0%)	166,360	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2000

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Local Health Area 56 Nechako

Age Group	Females		Males		Total	
< 1	147	(1.6%)	155	(1.6%)	302	(1.6%)
1 - 4	609	(6.8%)	627	(6.4%)	1,236	(6.6%)
5 - 9	789	(8.8%)	781	(8.0%)	1,570	(8.4%)
10 - 14	687	(7.7%)	817	(8.4%)	1,504	(8.0%)
15 - 19	730	(8.2%)	833	(8.5%)	1,563	(8.3%)
20 - 24	711	(7.9%)	725	(7.4%)	1,436	(7.7%)
25 - 29	601	(6.7%)	660	(6.8%)	1,261	(6.7%)
30 - 34	697	(7.8%)	690	(7.1%)	1,387	(7.4%)
35 - 39	746	(8.3%)	838	(8.6%)	1,584	(8.5%)
40 - 44	729	(8.1%)	839	(8.6%)	1,568	(8.4%)
45 - 49	621	(6.9%)	747	(7.6%)	1,368	(7.3%)
50 - 54	492	(5.5%)	596	(6.1%)	1,088	(5.8%)
55 - 59	373	(4.2%)	406	(4.2%)	779	(4.2%)
60 - 64	318	(3.6%)	344	(3.5%)	662	(3.5%)
65 - 69	246	(2.7%)	292	(3.0%)	538	(2.9%)
70 - 74	188	(2.1%)	201	(2.1%)	389	(2.1%)
75 - 79	121	(1.4%)	114	(1.2%)	235	(1.3%)
80 - 84	64	(0.7%)	69	(0.7%)	133	(0.7%)
85 +	81	(0.9%)	39	(0.4%)	120	(0.6%)
TOTALS:	8,950	(100.0%)	9,773	(100.0%)	18,723	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2005

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Local Health Area 56 Nechako

Age Group	Females		Males		Total	
< 1	145	(1.5%)	152	(1.5%)	297	(1.5%)
1 - 4	594	(6.2%)	626	(6.1%)	1,220	(6.1%)
5 - 9	765	(8.0%)	789	(7.7%)	1,554	(7.8%)
10 - 14	776	(8.1%)	779	(7.6%)	1,555	(7.8%)
15 - 19	660	(6.9%)	795	(7.7%)	1,455	(7.3%)
20 - 24	705	(7.4%)	790	(7.7%)	1,495	(7.5%)
25 - 29	733	(7.7%)	724	(7.0%)	1,457	(7.3%)
30 - 34	641	(6.7%)	682	(6.6%)	1,323	(6.7%)
35 - 39	717	(7.5%)	712	(6.9%)	1,429	(7.2%)
40 - 44	755	(7.9%)	842	(8.2%)	1,597	(8.0%)
45 - 49	729	(7.6%)	833	(8.1%)	1,562	(7.9%)
50 - 54	616	(6.4%)	748	(7.3%)	1,364	(6.9%)
55 - 59	487	(5.1%)	586	(5.7%)	1,073	(5.4%)
60 - 64	354	(3.7%)	385	(3.7%)	739	(3.7%)
65 - 69	288	(3.0%)	309	(3.0%)	597	(3.0%)
70 - 74	224	(2.3%)	248	(2.4%)	472	(2.4%)
75 - 79	160	(1.7%)	148	(1.4%)	308	(1.6%)
80 - 84	95	(1.0%)	74	(0.7%)	169	(0.9%)
85 +	111	(1.2%)	68	(0.7%)	179	(0.9%)
TOTALS:	9,555	(100.0%)	10,290	(100.0%)	19,845	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2010

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Local Health Area 56 Nechako

Age Group	Females		Males		Total	
< 1	139	(1.4%)	146	(1.4%)	285	(1.4%)
1 - 4	569	(5.7%)	601	(5.6%)	1,170	(5.7%)
5 - 9	741	(7.4%)	781	(7.3%)	1,522	(7.4%)
10 - 14	748	(7.5%)	781	(7.3%)	1,529	(7.4%)
15 - 19	746	(7.5%)	754	(7.1%)	1,500	(7.3%)
20 - 24	633	(6.3%)	746	(7.0%)	1,379	(6.7%)
25 - 29	715	(7.2%)	787	(7.4%)	1,502	(7.3%)
30 - 34	752	(7.5%)	733	(6.9%)	1,485	(7.2%)
35 - 39	638	(6.4%)	685	(6.4%)	1,323	(6.4%)
40 - 44	714	(7.2%)	707	(6.6%)	1,421	(6.9%)
45 - 49	751	(7.5%)	826	(7.8%)	1,577	(7.6%)
50 - 54	723	(7.2%)	829	(7.8%)	1,552	(7.5%)
55 - 59	609	(6.1%)	732	(6.9%)	1,341	(6.5%)
60 - 64	460	(4.6%)	557	(5.2%)	1,017	(4.9%)
65 - 69	320	(3.2%)	348	(3.3%)	668	(3.2%)
70 - 74	263	(2.6%)	264	(2.5%)	527	(2.6%)
75 - 79	191	(1.9%)	184	(1.7%)	375	(1.8%)
80 - 84	127	(1.3%)	100	(0.9%)	227	(1.1%)
85 +	142	(1.4%)	86	(0.8%)	228	(1.1%)
TOTALS:	9,981	(100.0%)	10,647	(100.0%)	20,628	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2015

1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Local Health Area 56 Nechako

Age Group	Females		Males		Total	
< 1	141	(1.4%)	149	(1.4%)	290	(1.4%)
1 - 4	568	(5.4%)	600	(5.4%)	1,168	(5.4%)
5 - 9	710	(6.8%)	748	(6.8%)	1,458	(6.8%)
10 - 14	728	(7.0%)	779	(7.1%)	1,507	(7.0%)
15 - 19	715	(6.9%)	760	(6.9%)	1,475	(6.9%)
20 - 24	724	(6.9%)	716	(6.5%)	1,440	(6.7%)
25 - 29	653	(6.3%)	749	(6.8%)	1,402	(6.5%)
30 - 34	749	(7.2%)	807	(7.3%)	1,556	(7.3%)
35 - 39	763	(7.3%)	746	(6.8%)	1,509	(7.0%)
40 - 44	638	(6.1%)	682	(6.2%)	1,320	(6.2%)
45 - 49	712	(6.8%)	700	(6.4%)	1,412	(6.6%)
50 - 54	746	(7.2%)	822	(7.5%)	1,568	(7.3%)
55 - 59	717	(6.9%)	813	(7.4%)	1,530	(7.1%)
60 - 64	579	(5.6%)	699	(6.3%)	1,278	(6.0%)
65 - 69	418	(4.0%)	510	(4.6%)	928	(4.3%)
70 - 74	295	(2.8%)	302	(2.7%)	597	(2.8%)
75 - 79	226	(2.2%)	202	(1.8%)	428	(2.0%)
80 - 84	154	(1.5%)	131	(1.2%)	285	(1.3%)
85 +	191	(1.8%)	103	(0.9%)	294	(1.4%)
TOTALS:	10,427	(100.0%)	11,018	(100.0%)	21,445	(100.0%)

BC Ministry of Health and
Ministry Responsible for Seniors

Population for 2020

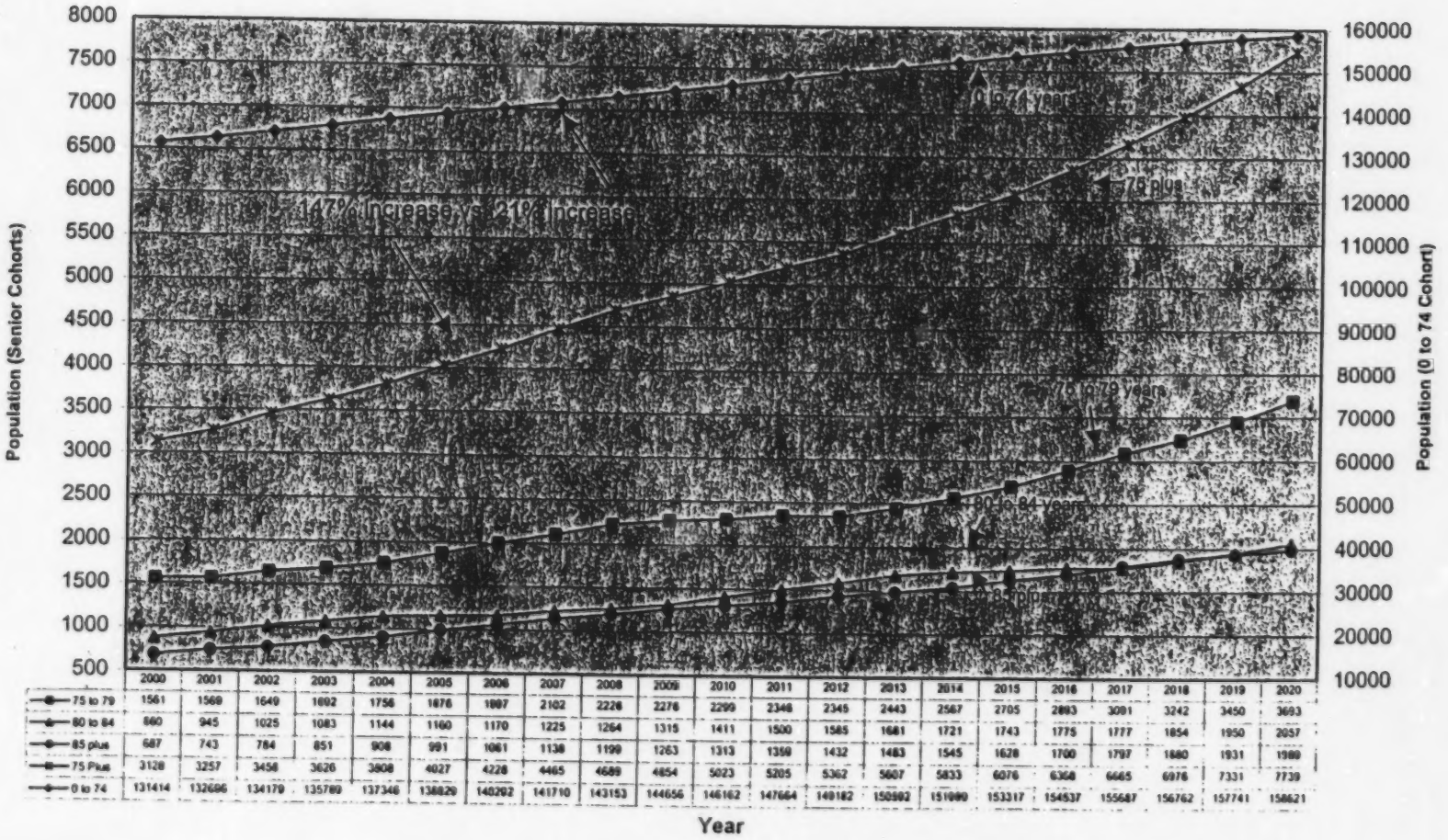
1. Data Source: PEOPLE24 (provided by BC STATS, Ministry of Finance and Corporate Relations)

Local Health Area 56 Nechako

Age Group	Females		Males		Total	
< 1	145	(1.3%)	152	(1.3%)	297	(1.3%)
1 - 4	582	(5.3%)	612	(5.4%)	1,194	(5.3%)
5 - 9	727	(6.7%)	764	(6.7%)	1,491	(6.7%)
10 - 14	695	(6.4%)	745	(6.5%)	1,440	(6.4%)
15 - 19	685	(6.3%)	754	(6.6%)	1,439	(6.4%)
20 - 24	684	(6.3%)	720	(6.3%)	1,404	(6.3%)
25 - 29	757	(6.9%)	728	(6.4%)	1,485	(6.6%)
30 - 34	714	(6.5%)	775	(6.8%)	1,489	(6.7%)
35 - 39	786	(7.2%)	830	(7.3%)	1,616	(7.2%)
40 - 44	785	(7.2%)	757	(6.6%)	1,542	(6.9%)
45 - 49	637	(5.8%)	691	(6.1%)	1,328	(5.9%)
50 - 54	707	(6.5%)	704	(6.2%)	1,411	(6.3%)
55 - 59	740	(6.8%)	810	(7.1%)	1,550	(6.9%)
60 - 64	684	(6.3%)	780	(6.8%)	1,464	(6.6%)
65 - 69	532	(4.9%)	640	(5.6%)	1,172	(5.2%)
70 - 74	388	(3.6%)	443	(3.9%)	831	(3.7%)
75 - 79	256	(2.3%)	232	(2.0%)	488	(2.2%)
80 - 84	187	(1.7%)	141	(1.2%)	328	(1.5%)
85 +	230	(2.1%)	140	(1.2%)	370	(1.7%)
TOTALS:	10,921	(100.0%)	11,418	(100.0%)	22,339	(100.0%)

Population Growth by Age Cohort NIRHB 2000 to 2020

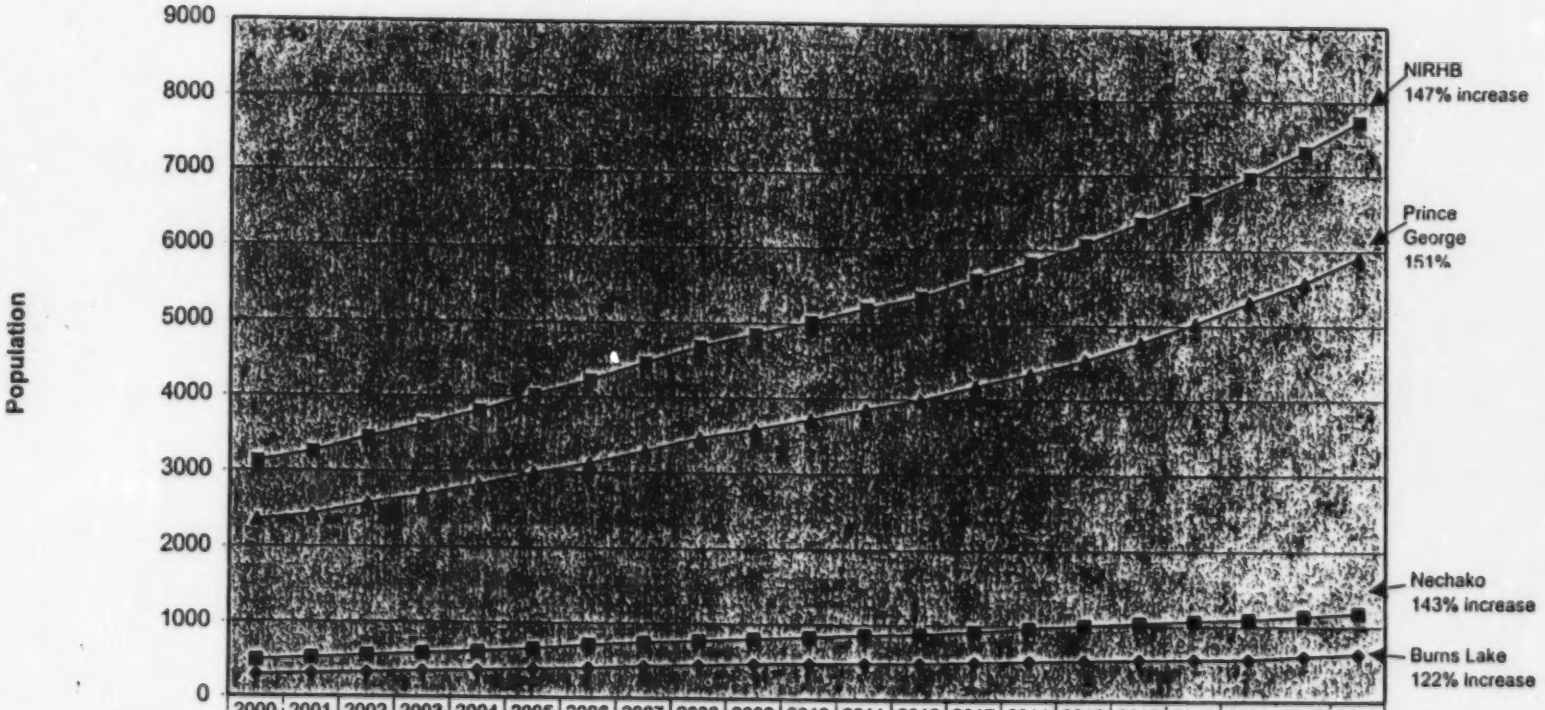
[based on PEOPLE 24; scaling proportionate]



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
75 to 79	1561	1569	1649	1692	1756	1876	1997	2102	2226	2276	2299	2346	2345	2443	2567	2705	2893	3091	3242	3450	3693
80 to 84	860	945	1025	1083	1144	1160	1170	1225	1264	1315	1411	1500	1585	1681	1721	1743	1775	1777	1854	1950	2057
85 plus	687	743	784	851	908	991	1061	1138	1199	1263	1313	1359	1432	1483	1545	1628	1700	1797	1880	1931	1980
75 Plus	3128	3257	3458	3626	3808	4027	4228	4465	4689	4854	5023	5205	5362	5607	5833	6076	6368	6665	6976	7331	7739
0 to 74	131414	132696	134179	135789	137346	138829	140292	141710	143153	144656	146162	147664	149182	150892	151999	153317	154537	155687	156762	157741	158621

Population Growth for the NIRHB 2000 to 2020 (Age >= 75)

[based on PEOPLE 24]

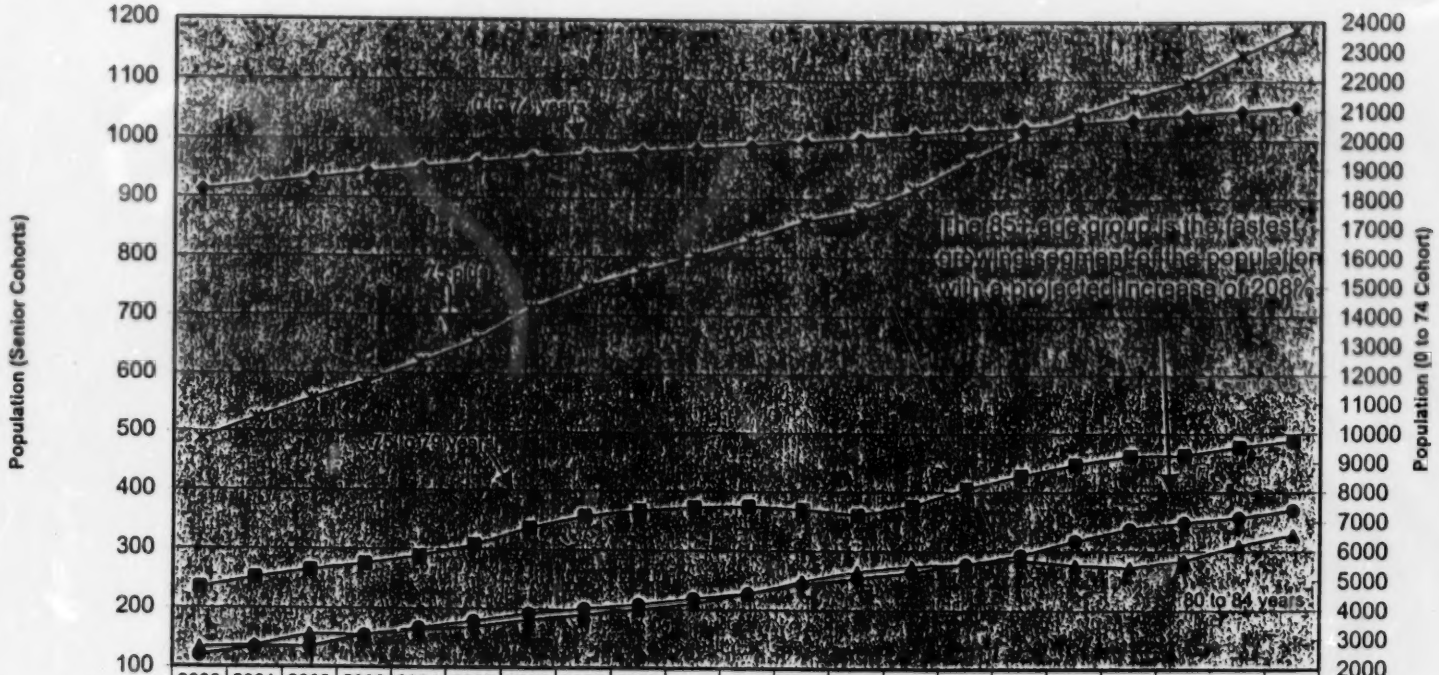


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Burns Lake	286	309	327	349	362	384	398	430	448	468	477	485	491	511	522	536	549	561	564	607	636
Nechako	488	523	556	586	619	656	710	748	775	802	830	862	880	915	964	1007	1042	1073	1097	1144	1186
Prince George	2354	2425	2575	2691	2827	2987	3120	3287	3466	3584	3716	3858	3991	4181	4347	4533	4777	5031	5315	5580	5917
NIRHB	3128	3257	3458	3626	3808	4027	4228	4465	4689	4854	5023	5205	5362	5607	5833	6076	6368	6665	6976	7331	7739

Year

Population Growth by Age Cohort NECHAKO 2000 to 2020

[based on PEOPLE 24; scaling proportionate]



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
75 to 79	235	252	265	276	289	308	337	357	367	373	375	370	361	376	406	428	447	462	463	477	488
80 to 84	133	137	156	155	163	169	181	190	200	210	227	249	265	275	279	285	277	273	285	310	328
85 plus	120	134	135	155	167	179	192	201	208	219	228	243	254	264	279	294	318	338	349	357	370
75 plus	488	523	556	586	619	656	710	748	775	802	830	862	880	915	964	1007	1042	1073	1097	1144	1186
0 to 74	1823	1842	1863	1883	1901	1918	1934	1947	1959	1969	1979	1991	2005	2018	2030	2043	2057	2072	2088	2101	2115

Year

BC Ministry of Health and Ministry Responsible for Seniors

Indirect Age-Standardized Utilization Rates

Based On 1998/1999 Morbidity Data

TABLE 1

Appendix 3a

Notes:

1. The report is based on data for Alt. Level of Care care levels (no newborns.)
2. Rates are per 1,000 population, standardized over 19 age groups using the indirect method and PEOPLE24 population data.
3. Provincial totals and rates are: Cases=10,351; Days=265,394; RIW=0.0; ALOS=25.6; RIW/Case=0.000; Cases Rate=2.58; Days Rate=66; RIW Rate=0.00; Population=4,009,922 based on PEOPLE24. These totals do not include non-residents.

Local Health Area	Population	% > 65	Cases Rate	Days Rate	RIW Rate
27 Cariboo-Chilcotin	29,312	7%	4.49	207	
28 Quesnel	27,688	9%	2.36	60	
30 South Cariboo	7,863	13%	2.69	55	
52 Prince Rupert	19,023	7%	6.45	237	
54 Smithers	18,871	6%	5.07	267	
55 Burns Lake	7,832	9%	1.12	115	
56 Nechako	18,402	7%	2.33	93	
57 Prince George	107,375	6%	3.18	140	
59 Peace River South	29,532	8%	2.08	34	
60 Peace River North	30,125	6%	3.06	168	
88 Terrace	23,975	6%	2.18	98	
Provincial Totals:	**4,009,922**	**13%**	**2.58**	**66**	**0.00**

BC Ministry of Health and Ministry Responsible for Seniors

Indirect Age-Standardized Utilization Rates

Based On 1998/1999 Morbidity Data

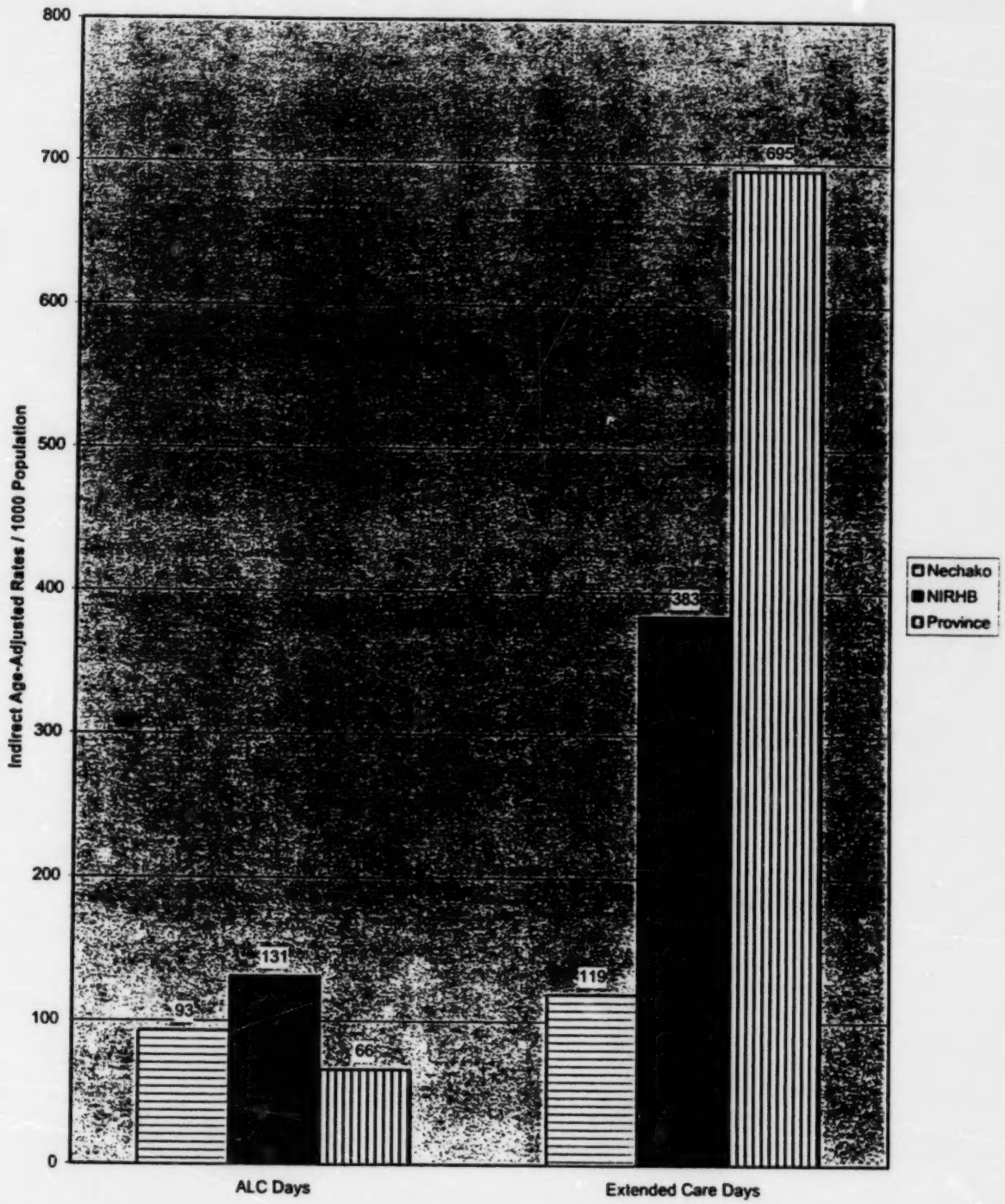
TABLE 1

Notes:

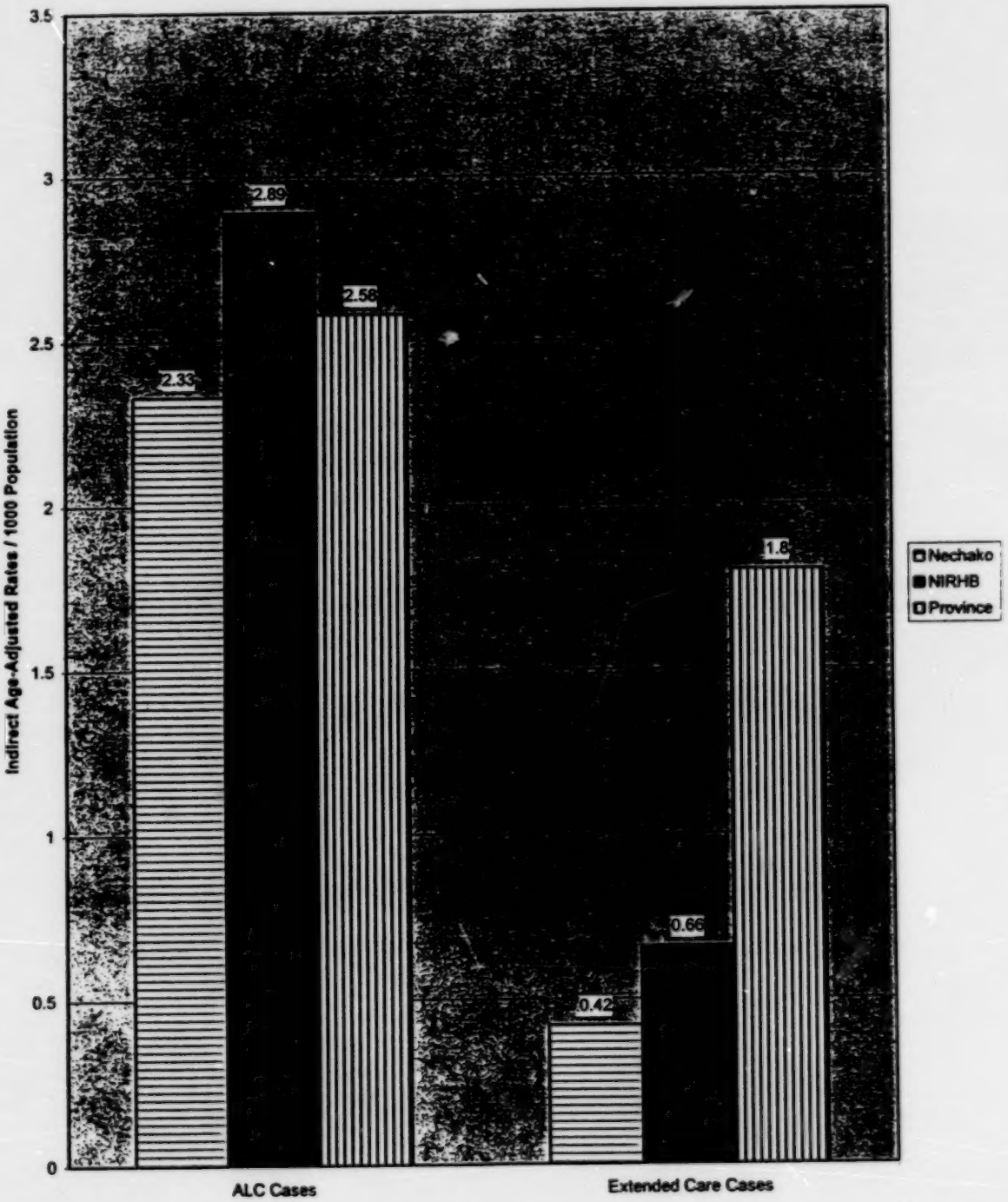
1. The report is based on data for Alt. Level of Care care levels (no newborns.)
2. Rates are per 1,000 population, standardized over 19 age groups using the indirect method and PEOPLE24 population data.
3. Provincial totals and rates are: Cases=10,351; Days=265,394; RIW=0.0; ALOS=25.6; RIW/Case=0.000; Cases Rate=2.58; Days Rate=66; RIW Rate=0.00; Population=4,009,922 based on PEOPLE24. These totals do not include non-residents.

Health Region	Population	% > 65	Cases Rate	Days Rate	RIW Rate
12 Cariboo	76,761	9%	3.29	119	
13 North West	91,674	6%	4.32	211	
14 Peace Liard	66,237	6%	2.85	97	
15 Northern Interior *	133,609	6%	2.89	131	
Provincial Totals:	**4,009,922**	**13%**	**2.58**	**66**	**0.00**

Selected Utilization Rates - PURRFECT 5.0 - 1998/99



Selected Utilization Rates - PURRFECT 5.0 - 1998/99



BC Ministry of Health and Ministry Responsible for Seniors

Indirect Age-Standardized Utilization Rates

Based On 1998/1999 Morbidity Data

TABLE 1

Appendix 3d

Notes:

1. The report is based on data for Extended Care care levels (no newborns.)
2. Rates are per 1,000 population, standardized over 19 age groups using the indirect method and PEOPLE24 population data.
3. Provincial totals and rates are: Cases=7,221; Days=2,788,407; RIW=0.0; ALOS=386.2; RIW/Case=0.000; Cases Rate=1.80; Days Rate=695; RIW Rate=0.00; Population=4,009,922 based on PEOPLE24. These totals do not include non-residents.

Local Health Area	Population	% > 65	Cases Rate	Days Rate	RIW Rate
27 Cariboo-Chilcotin	29,312	7%	2.35	1,064	
28 Quesnel	27,688	9%	1.83	1,428	
30 South Cariboo	7,863	13%	1.40	480	
52 Prince Rupert	19,023	7%	0.98	668	
54 Smithers	18,871	6%	0.52	21	
56 Nechako	18,402	7%	0.42	119	
57 Prince George	107,375	6%	0.78	479	
59 Peace River South	29,532	8%	2.23	965	
60 Peace River North	30,125	6%	1.83	1,090	
88 Terrace	23,975	6%	1.55	460	
Provincial Totals:	**4,009,922**	**13%**	**1.80**	**695**	**0.00**

BC Ministry of Health and Ministry Responsible for Seniors

Indirect Age-Standardized Utilization Rates

Based On 1998/1999 Morbidity Data

TABLE 1

Notes:

1. The report is based on data for Extended Care care levels (no newborns.)
2. Rates are per 1,000 population, standardized over 19 age groups using the indirect method and PEOPLE24 population data.
3. Provincial totals and rates are: Cases=7,221; Days=2,788,407; RIW=0.0; ALOS=386.2; RIW/Case=0.000; Cases Rate=1.80; Days Rate=695; RIW Rate=0.00; Population=4,009,922 based on PEOPLE24. These totals do not include non-residents.

Health Region	Population	% > 65	Cases Rate	Days Rate	RIW Rate
12 Cariboo	76,761	9%	1.73	1,019	
13 North West	91,674	6%	1.46	584	
14 Peace Liard	66,237	6%	2.06	1,024	
15 Northern Interior	133,609	6%	0.66	383	
Provincial Totals:	**4,009,922**	**13%**	**1.80**	**695**	**0.00**

B.C. Ministry of Health and
Ministry Responsible for Seniors

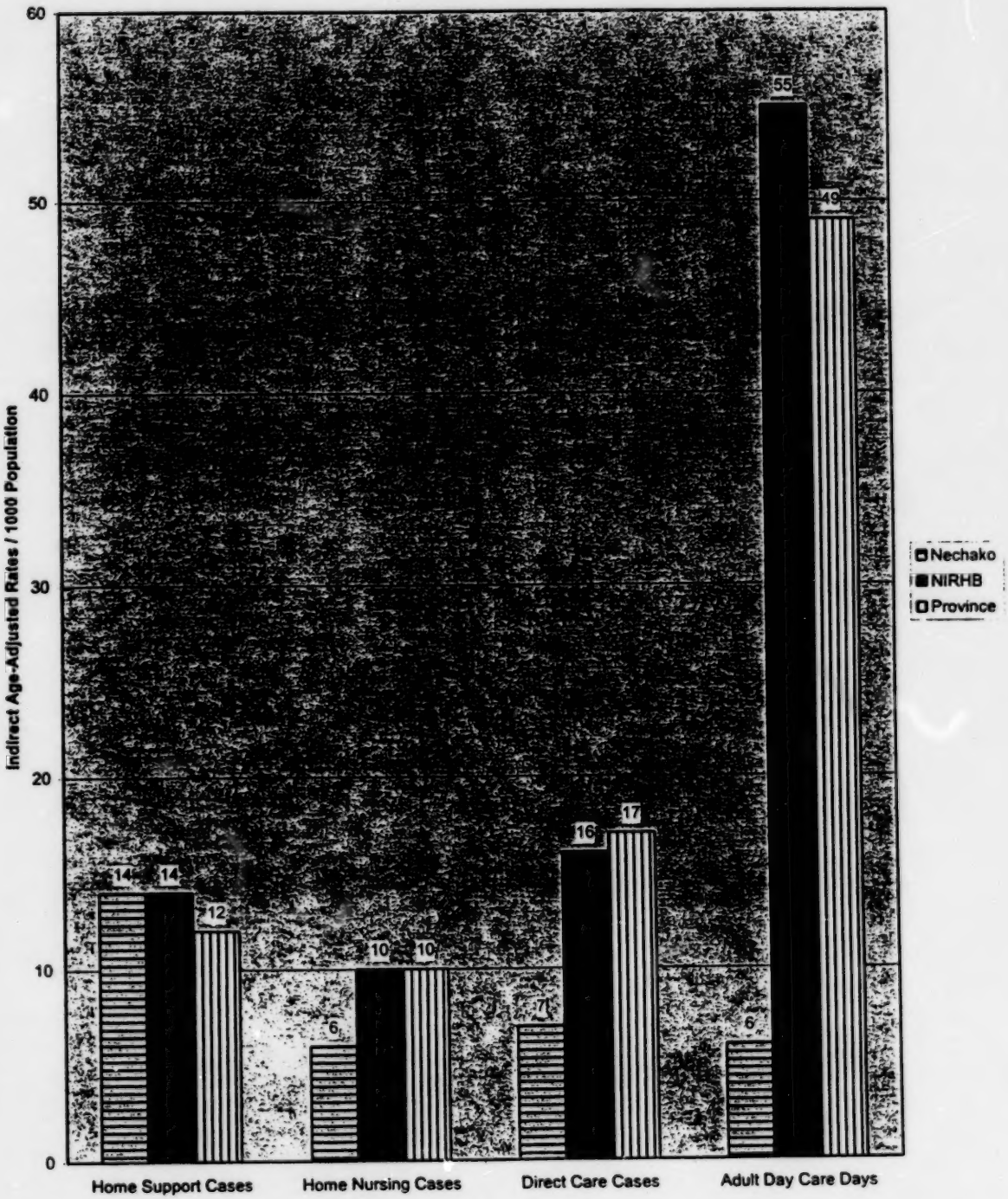
Selected Utilization Rates

		1998/99 Population	1998/99 Population	1998/99 Cont Care Adult Day Care	1998/99 Cont Care Adult Day Care	1998/99 Cont Care Direct Care	1998/99 Cont Care Home Nursing	1998/99 Cont Care Home Support	1998/99 Cont Care Home Support	
		Percent Over 65	*Total Population*	Cases	*Days*	Cases	Cases	Cases	*Hours*	
HR	12	8.6%	76,761	2	79	15	8	18	2,667	Cariboo
	13	6.2%	91,674	2	127	17	13	12	2,061	North West
	14	6.4%	66,237	2	36	27	24	17	1,996	Peace-Liard
	15	6.3%	133,609	2	55	16	10	14	1,941	Northern Interior
LHA	27	7.1%	29,312	0	3	17	10	17	2,431	Cariboo-Chilcotin
	28	8.6%	27,666	3	87	16	10	14	1,826	Quesnel
	30	13.2%	7,863			16	12	10	1,171	South Cariboo
	52	6.6%	19,023	2	10	21	15	10	1,202	Prince Rupert
	54	6.1%	18,871	3	174	29	23	15	2,718	Smithers
	55	9.3%	7,832	2	116	6	4	16	3,055	Burns Lake
	56	7.1%	18,402	0	6	7	6	14	1,819	Nechako
	57	5.9%	107,375	2	58	19	11	13	1,848	Prince George
	59	7.8%	29,532	0	0	35	31	19	2,299	Peace River South
	60	5.8%	30,125	4	86	19	15	14	1,751	Peace River North
	88	6.3%	23,975	2	75	15	12	13	2,210	Terrace
HR	99	12.7%	4,009,922	1	49	17	10	12	1,940	Province

Appendix 3e

All service data stated as indirect age-adusted rates per 1,000 population, unless otherwise noted in column title eg., ' actual cases', 'crude days'.
MSP Actuals are listed in units/1,000. Rates are based upon People24 population database.
MSP data (if shown) is for Fee-for-Service items only. If less than 500 services, Actual Services = 0.
Utilization Rates by Health Program and Year Ver. 1.50: 'RatesReport1:Group by Year' Printed: 20-Apr-00

Selected Utilization Rates - PURRFECT 5.0 - 1998/99



B.C. Ministry of Health and
Ministry Responsible for Seniors

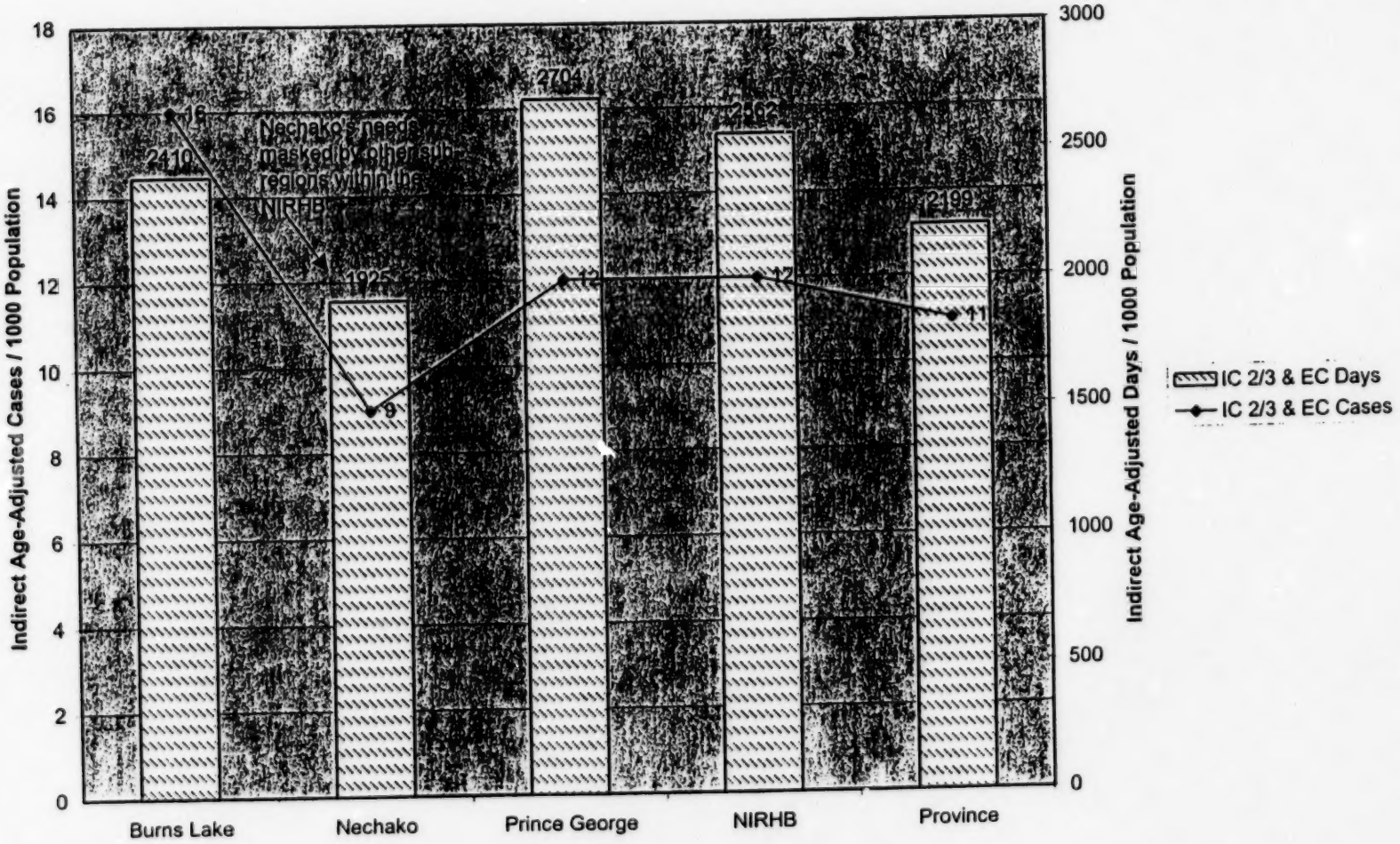
Selected Utilization Rates

		1998/99 Population	1998/99 Population	1998/99 Cont Care IC2 + IC3 + EC	1998/99 Cont Care IC2 + IC3 + EC	
		Percent Over 65	*Total Population*	*Cases*	*Days*	
HR	12	8.6%	76,761	12	2,539	Cariboo
	13	6.2%	91,674	11	2,360	North West
	14	6.4%	66,237	14	3,120	Peace-Liard
	15	6.3%	133,609	12	2,562	Northern Interior
LHA	27	7.1%	29,312	14	3,157	Cariboo-Chilcotin
	28	8.6%	27,688	14	3,011	Quesnel
	30	13.2%	7,863	8	1,343	South Cariboo
	52	6.6%	19,023	14	3,124	Prince Rupert
	54	6.1%	18,871	10	2,012	Smithers
	55	9.3%	7,832	16	2,410	Burns Lake
	56	7.1%	18,402	9	1,925	Nechako
	57	5.9%	107,375	12	2,704	Prince George
	59	7.8%	29,532	15	3,427	Peace River South
	60	5.8%	30,125	13	2,740	Peace River North
	88	6.3%	23,975	14	2,954	Terrace
HR	99	12.7%	4,009,922	11	2,199	Province

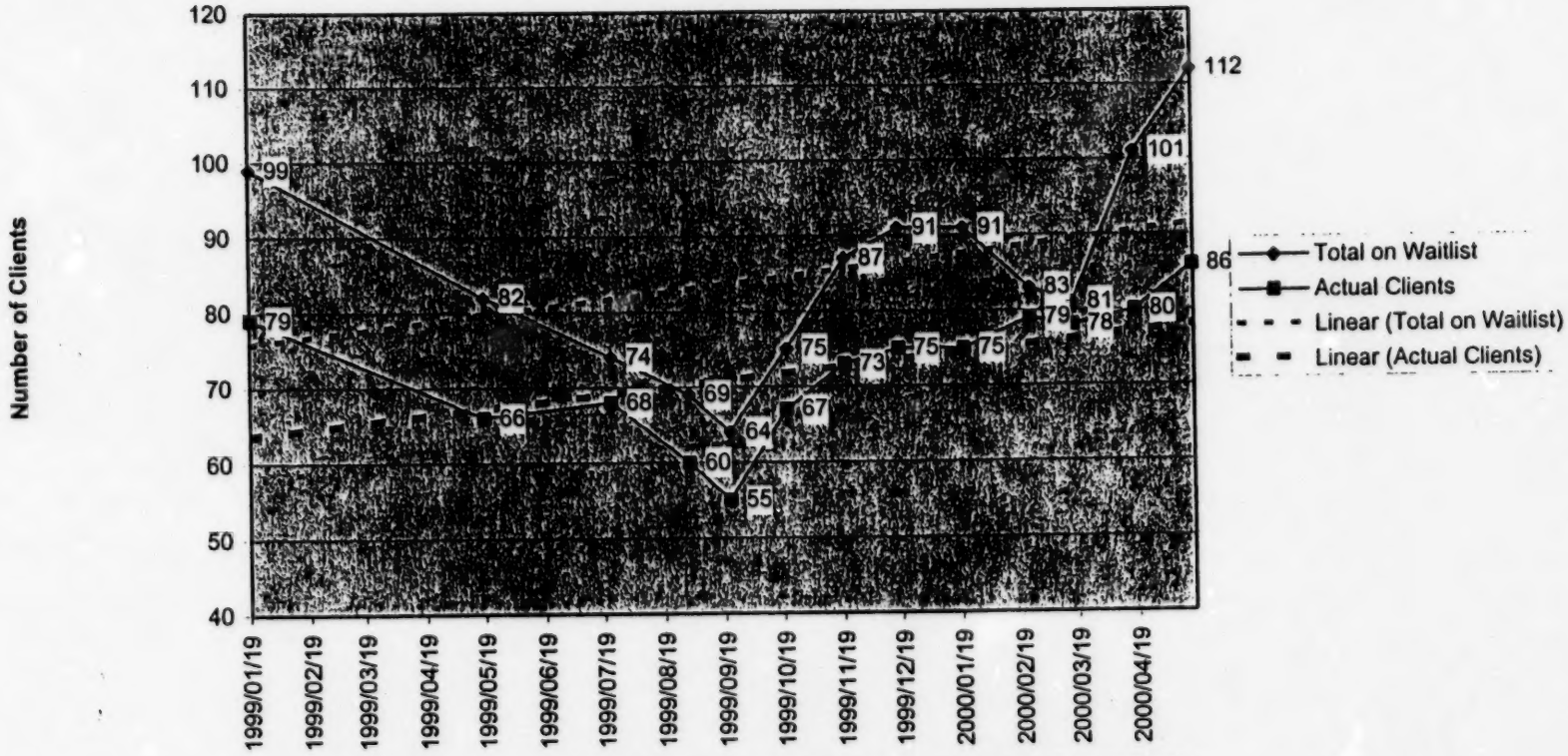
Appendix 3g

All service data stated as indirect age-adusted rates per 1,000 population, unless otherwise noted in column title eg., ' actual cases', 'crude days'.
MSP Actuals are listed in units/1,000. Rates are based upon People24 population database.
MSP data (if shown) is for Fee-for-Service items only. If less than 500 services, Actual Services = 0.
Utilization Rates by Health Program and Year Ver. 1.50: 'RatesReport1:Group by Year' Printed: 20-Apr-00

Selected Utilization Rates - Continuing Care - IC 2/3 & EC - PURRFECT 5.0



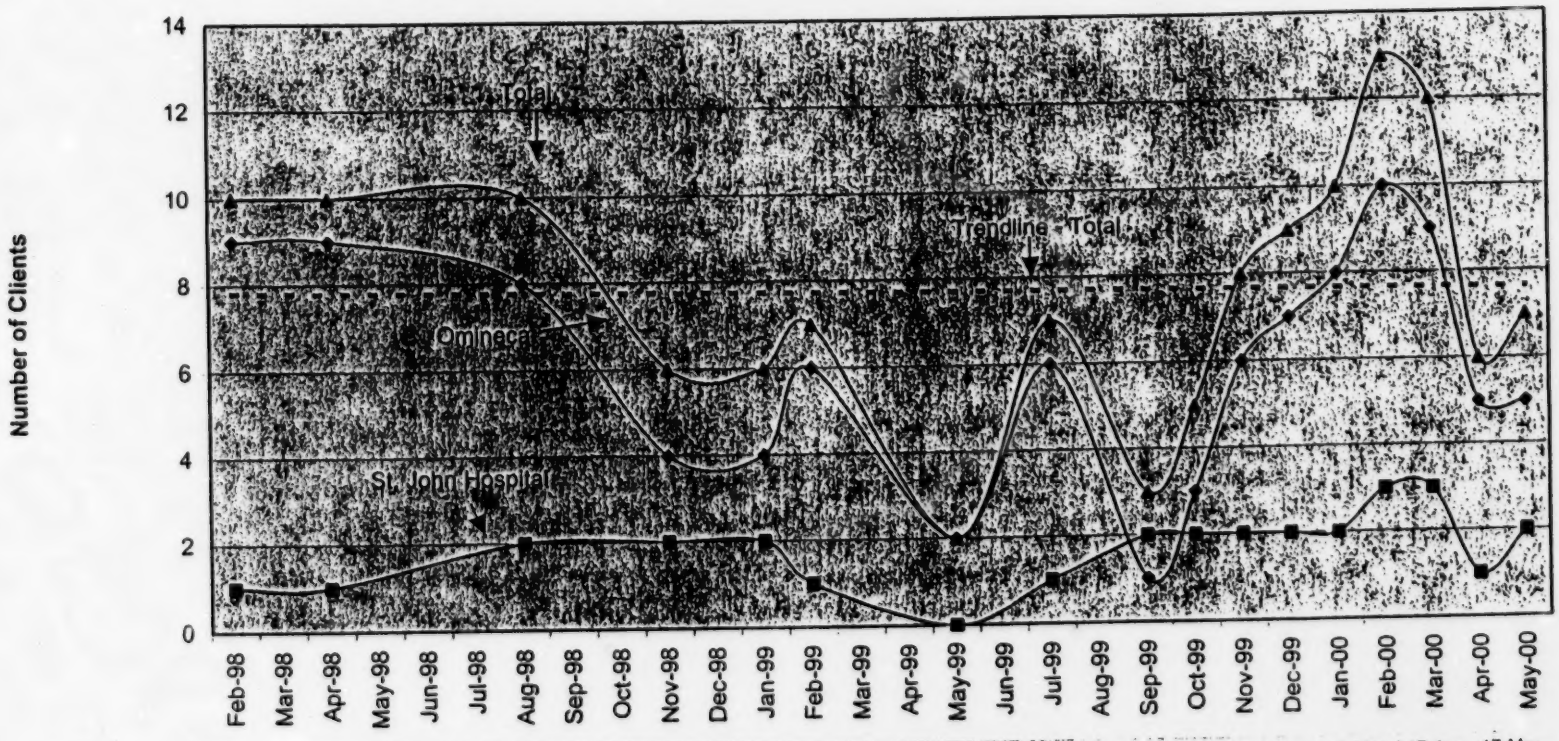
NIRHB LTC Waitlist History January 1999 to May 2000



	19-Jan-99	18-May-99	22-Jul-99	31-Aug-99	21-Sep-99	20-Oct-99	19-Nov-99	17-Dec-99	20-Jan-00	23-Feb-00	16-Mar-00	17-Apr-00	17-May-00
Total on Waitlist	99	82	74	69	64	75	87	91	91	83	81	101	112
Actual Clients	79	66	68	60	55	67	73	75	75	79	78	80	86

Time

Waitlist History for Omineca Lodge and St. John Hospital February 1998 to May 2000



	13-Feb-98	14-Apr-98	24-Aug-98	16-Nov-98	19-Jan-99	16-Feb-99	18-May-99	22-Jul-99	17-Sep-99	20-Oct-99	19-Nov-99	20-Dec-99	21-Jan-00	18-Feb-00	16-Mar-00	17-Apr-00	17-May-00
Omineca	9	9	8	4	4	6	2	6	1	3	6	7	8	10	9	5	5
St.John Hospital	1	1	2	2	2	1	0	1	2	2	2	2	2	3	3	1	2
Total	10	10	10	6	6	7	2	7	3	5	8	9	10	13	12	6	7

Time

NIRHB Residential Facility Census by Care Level
as at March 31

Appendix 5A

Omineca Lodge	PC	IC1	IC2	IC3	EC	Total
1994	0	1	13	16	4	34
1995	0	0	12	17	6	35
1996	0	0	15	18	2	35
1997	0	0	14	17	4	35
1998	0	0	15	17	3	35
1999	0	0	20	13	2	35
2000	0	0	19	14	2	35

Parkside	PC	IC1	IC2	IC3	EC	Total
1994	0	3	24	26	5	58
1995	0	3	26	25	6	60
1996	0	3	28	25	4	60
1997	0	3	34	19	4	60
1998	0	0	35	20	4	59
1999	0	0	33	23	4	60
2000	0	0	43	18	0	61

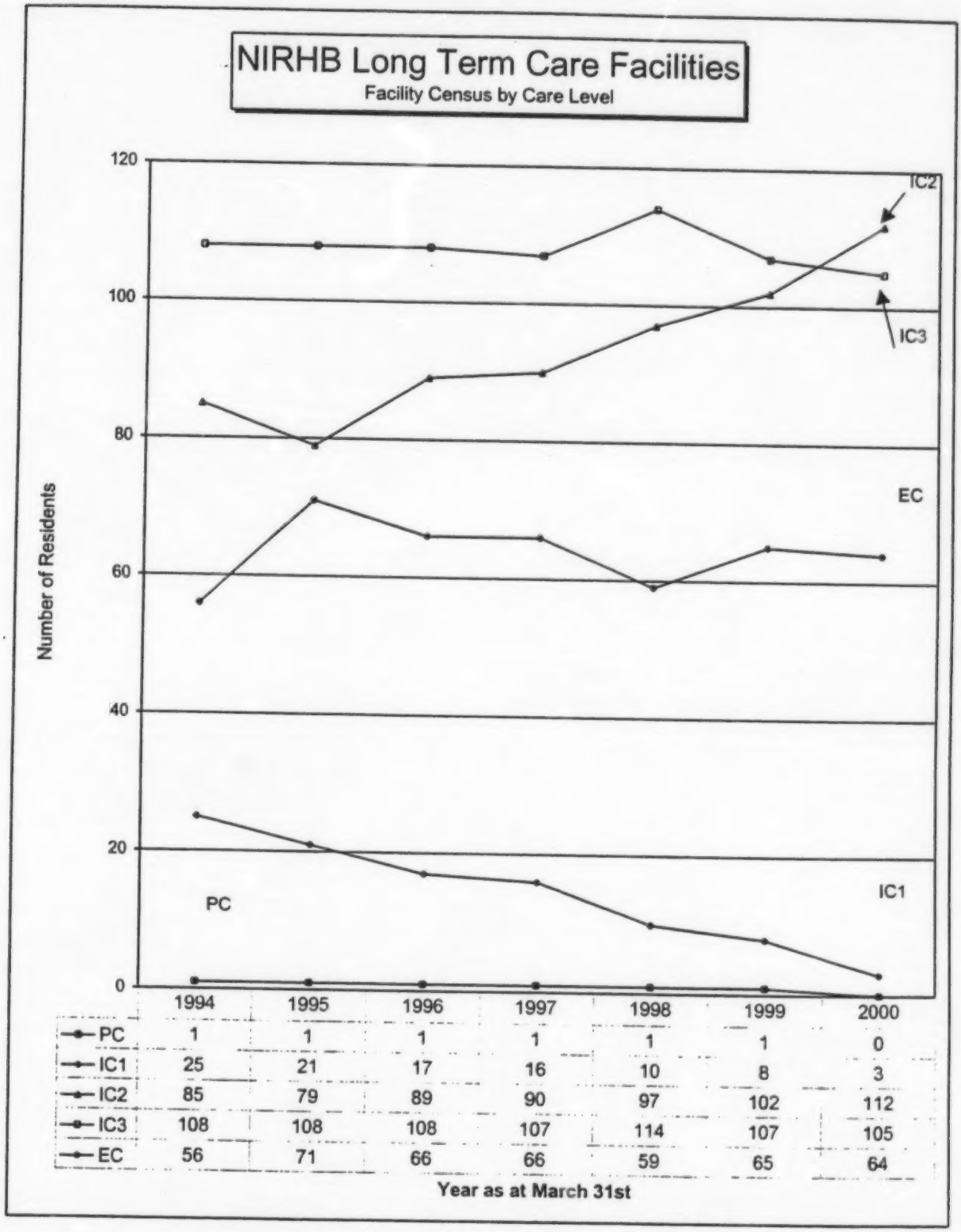
Rainbow	PC	IC1	IC2	IC3	EC	Total
1994	1	15	16	5	2	39
1995	1	13	15	9	2	40
1996	1	11	19	9	1	41
1997	1	9	21	9	0	40
1998	1	6	23	8	2	40
1999	1	4	27	7	0	39
2000	0	2	30	6	1	39

Simon Fraser Lodge	PC	IC1	IC2	IC3	EC	Total
1994	0	2	19	57	36	114
1995	0	2	13	54	46	115
1996	0	0	14	52	49	115
1997	0	0	10	57	48	115
1998	0	0	10	63	40	113
1999	0	0	7	58	50	115
2000	0	0	10	59	45	114

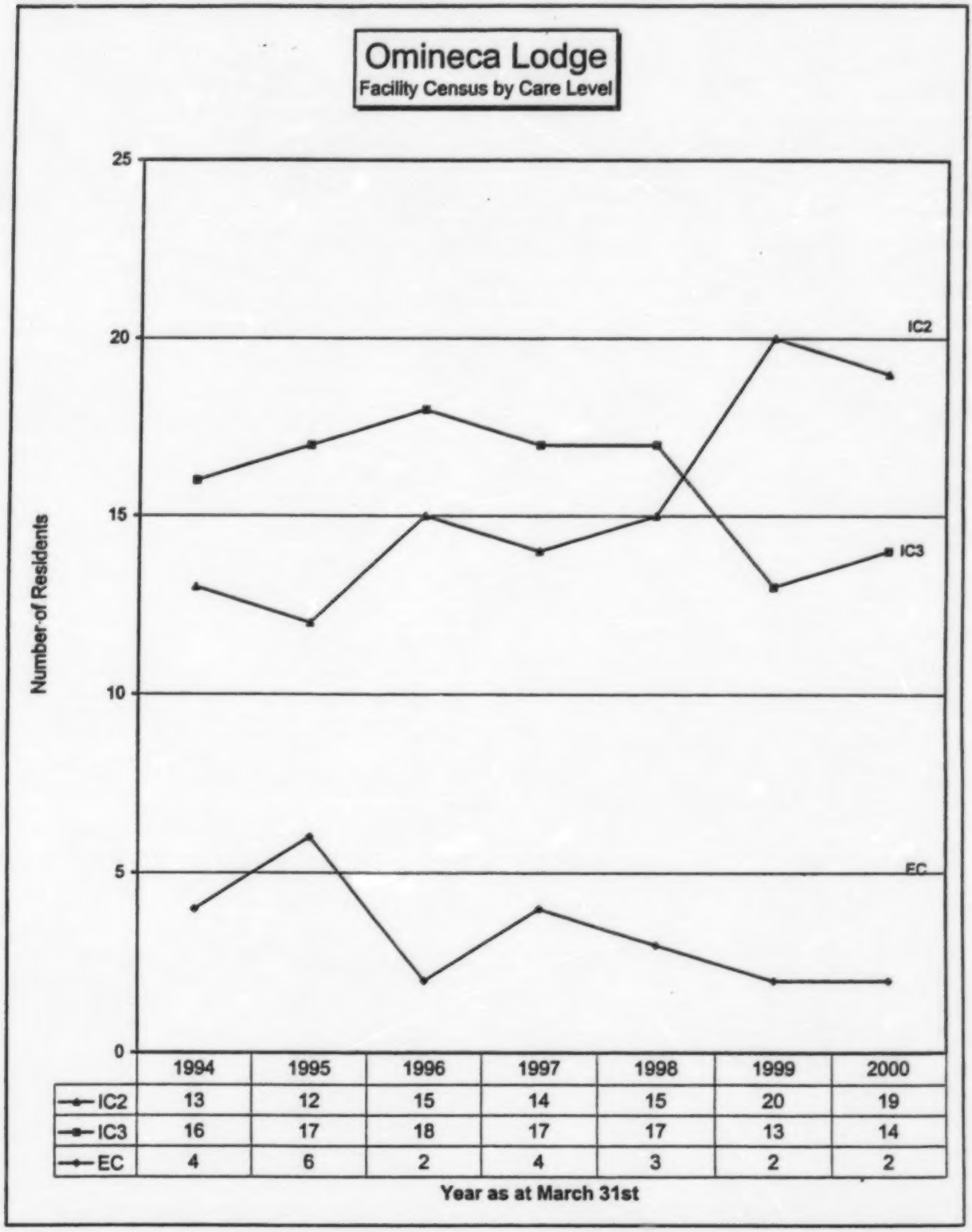
The Pines	PC	IC1	IC2	IC3	EC	Total
1994	0	4	13	4	9	30
1995	0	3	13	3	11	30
1996	0	3	13	4	10	30
1997	0	4	11	5	10	30
1998	0	4	14	6	10	34
1999	0	4	15	6	9	34
2000	0	1	10	8	16	35

Total Region*	PC	IC1	IC2	IC3	EC	Total
1994	1	25	85	108	56	275
1995	1	21	79	108	71	280
1996	1	17	89	108	66	281
1997	1	16	90	107	66	280
1998	1	10	97	114	59	281
1999	1	8	102	107	65	283
2000	0	3	112	105	64	284

* Total Region* excludes St.John Hospital, McBride Hospital, and Jubilee Lodge



	1994	1995	1996	1997	1998	1999	2000
PC	1	1	1	1	1	1	0
IC1	25	21	17	16	10	8	3
IC2	85	79	89	90	97	102	112
IC3	108	108	108	107	114	107	105
EC	56	71	66	66	59	65	64


Omineca Lodge
Facility Census by Care Level
Number of Residents
25
20
15
10
5
0
IC2
IC3
EC
1994 1995 1996 1997 1998 1999 2000
IC2 13 12 15 14 15 20 19
IC3 16 17 18 17 17 13 14
EC 4 6 2 4 3 2 2
Year as at March 31st

APPENDIX C

MULTILEVEL CARE COSTING GUIDELINES

MULTILEVEL SERVICE COSTING GUIDELINES 2000/2001
ATTACHED UNITS - NON - PROFIT FACILITIES

PROVIDER NAME: Ominoca Lodge and ADC

PROVIDER NO:

TOTAL MLS BEDS:	50.5			
OCCUP. RATE:	1			
PATIENT DAYS	18,433			
FLOOR AREA (SQ. M., SQ. FT.)	3,138	33,828		
MEAL DAYS	20,276			
CARE LEVEL OF CLIENTS	IC1	IC2	IC3	EC
Funded Care Levels less E.C. Clients	0.00	0.00	35.00	15.50
Actual Funded Care Levels	0.00	0.00	35.00	15.50

COST CATEGORY		Guideline Fte's	Facility Budget	Variance	Guideline Salary	Facility Budget	Variance
SALARIES & BENEFITS							
DIRECTOR OF CARE	1/150 BDS	1.00	0.60	(0.40)	$51,275	$30,765	($20,510)
PROFESSIONAL	FORMULA	3.83	7.05	3.22	185,169	$340,845	155,676
NON-PROFESSIONAL	FORMULA	13.72	19.80	6.08	528,138	$762,181	234,043
		18.55	27.45	8.90	764,582	1,133,792	369,210
PHARMACIST	1/150 BDS	0.34		(0.34)	21,029		(21,029)
PHARMACY AIDE	.5/150 BDS	0.17		(0.17)	6,585		(6,585)
O.T./P.T. COMBINED	1/50 BEDS	1.01	0.67	(0.34)	56,049	$37,181	(18,868)
SOCIAL WORKER	1/150 BEDS	0.34	0.33	(0.01)	18,868	$18,313	(555)
		1.86	1.00	(0.86)	102,531	55,494	(47,037)
DIETICIAN	.5/150 BDS	0.17	0.17	0.00	9,776	$9,776	0
DIETETIC STAFF	FORMULA	7.60	4.33	(3.27)	267,270	$152,273	(114,997)
		7.77	4.50	(3.27)	277,046	162,050	(114,996)
ADMINISTRATOR	1/150,+	1.00		(1.00)	56,722	$0	(56,722)
HUMAN RESOURCES	.5/150 BEDS	0.17		(0.17)	5,998		(5,998)
HEALTH RECORDS	.5/150 BEDS	0.17		(0.17)	5,998		(5,998)
SWITCHBOARD	NIL	0.00	0.50	0.50	0	$17,643	17,643
PAYABLES/REC/COMFORT ACCTS	1/150 BEDS	0.34	0.30	(0.04)	11,997	$10,586	(1,411)
VOLUNTEER COORDINATOR	.5 OR 1	0.50	1.00	0.50	19,643	$39,286	19,643
ACCOUNTANT/MANAGER	NIL	0.00		0.00	0		0
SECRETARY/STOREMAN/UNIT CLERK	SCALE	2.00		(2.00)	70,560		(70,560)
MATERIEL MANAGEMENT (BUYER)	NIL	0.00		0.00	0		0
		4.18	1.80	(2.38)	170,948	67,514	(103,434)
DIRECTOR, ENVIRON. SERVICES	NIL	0.00		0.00	0		0
LAUNDRY - PERSONAL	1/150 BEDS	0.34	0.30	(0.04)	11,413	$10,071	(1,342)
LAUNDRY - DISTRIBUTION	1/100 BEDS	0.51	0.50	(0.01)	17,120	$16,784	(336)
HOUSEKEEPING-CLEANER/AIDES	1/7K FT2	3.83	3.20	(0.63)	128,709	$107,538	(21,171)
HOUSEKEEPING SUPERVISOR	1 F.T.E.	1.00		(1.00)	33,120		(33,120)
SECURITY	NIL	0.00		0.00	0		0
PHYSICAL PLANT STAFF	SCALE	1.69	0.60	(1.09)	57,705	$20,487	(37,218)
		7.37	4.60	(2.77)	248,067	154,879	(93,188)
EMPLOYEE HEALTH NURSE	1/500 EMPL	0.11		(0.11)	5,318		(5,318)
PAYROLL	1/500 EMPL	0.11		(0.11)	3,882		(3,882)
EDUCATION & QA COORDINATOR	1/500 EMPL	0.11		(0.11)	5,318		(5,318)
		0.33	0.00	(0.33)	14,518	0	(14,518)
TOTAL FTES/SALARIES		40.06	39.35	(0.71)	1,577,692	1,573,730	(3,962)
ADD: RELIEF @ 17%					268,208	267,534	(674)
ADD: BENEFITS @ 19%		2.16			350,721	299,009	(51,712)
E.C. BED ADJUSTMENT		0.4531			444,949		(444,949)
TOTAL SALARIES & BENEFITS					$2,641,570	$2,140,272	($501,298)

MULTILEVEL SERVICE COSTING GUIDELINES 2000/2001
ATTACHED UNITS - NON - PROFIT FACILITIES

PROVIDER NAME: Ominica Lodge and ADC

PROVIDER NO:

TOTAL MLS BEDS: 50.5

OCCUP. RATE: 1

			(1) Guideline	(2) Facility	(1-2) New Money
ADMINISTRATION & SUPPLY					
MEDICAL/SURGICAL SUPPLIES (/PD)	SCALE		$20,601	$20,601	$0
DRUGS (/PD)	$1.256		$23,151	$23,151	0
DIETARY FOOD & SUPPLIES (/PD)	$5.202		$95,884	$95,884	0
PAT CARE DIAG & THERAP. (/PD)	$0.446		$8,229	$8,229	0
ADMIN & GENERAL SUPPORT (/PD)	$3.148		$58,021	$58,021	0
LINEN & LAUNDRY (/PD)	$0.452	*PURCHASED SERVICE	$93,238	$93,238	0
HOUSEKEEPING (/SQ M)	$4.182		$13,123	$13,123	0
PLANT OPERATION (/SQ M)	$15.588		$48,916	$48,916	0
TOTAL ADMINISTRATION & SUPPLY			$361,163	$361,163	$0
PROPERTY					
PLANT MAINTENANCE (/SQ M)	$10.85		$34,047	$34,047	
TOTAL PROPERTY			$34,047	$34,047	0
TOTAL COST			$3,036,780	$2,535,482	(501,298)
		GROSS PER DIEM	$184.75	$137.55	($27.20)
(LESS USER FEES)	$26.30	PER RESIDENT DAY	($484,775)	($484,775)	($484,775)
TOTAL NET COST			$2,552,005	$2,050,707	(501,298)
ESTIMATED ACTUAL PER DIEM BASED ON FULL ACCOMMODATION ADJUSTMENT ($26.80)			$138.45	$111.26	($27.20)

E.C. BED ADJUSTMENT	
M.L.C. - I.C.3 Rate	$52.76
100 bed Acute E.C. Model	$131.41
Variance	$78.65
# of E.C. Beds	15.5
E.C. Bed Adjustment	$444,949

FLAT RATE CHECK	Beds	Annual	$$
I.C.1 Rate			
$16.85	0	365	$0
I.C.2 Rate			
$16.85	0	365	$0
I.C.3 Rate			
$52.76	35	365	$674,038
$0.00			
$52.76			
E.C. Rate			
131.41	15.5	365	$743,452
			$1,417,490
			$76.00

ANNUAL GRANT	(1) Guideline	(2) Facility	(1-2) New Money
Gross Total Cost	$3,036,780	$2,535,482	$501,298
Less: CCD User Fee @ $26.30	($484,775)	$0	($484,775)
A & E $ 3.98	$ (80,697)		($80,697)
Net Grant Total	$ 2,471,308	$ 2,535,482	$ (64,174)
	$134.07	$137.55	($3.48)

CURRENT GRANT Effective Date:	(1) Guideline	(2) Facility	(1-2) New Money
Gross Total Cost	$3,036,780	$2,980,431	$56,349
Less: CCD User Fee @ $26.30	($484,775)	($484,775)	$0
A & E $ 3.98	$ (80,697)	($80,697)	($0)
Net Grant Total	$2,471,308	$2,414,959 #	$56,349
	$134.07	$221.47	$3.06

MULTILEVEL SERVICE COSTING GUIDELINES 2000/2001
ATTACHED UNITS - NON - PROFIT FACILITIES

PROVIDER NAME: Ominaca Lodge and ADC

PROVIDER NO:

TOTAL MLS BEDS: 50.5

OCCUP. RATE: 1

			Guideline Salary
DIRECTOR OF CARE	CCERA	Scale	$51,275
PROFESSIONAL	BCNU-4th	24.72	$48,347
NON-PROFESSIONAL /Care Aide	Care Aide	19.69	$38,494
PHARMACIST	HSA-Grid 11	31.63	$61,849
PHARMACY AIDE	PC11-12M	19.81	$38,736
O.T./P.T. COMBINED	HSA-Grid 13	28.38	$55,494
SOCIAL WORKER	HSA-Grid 11	28.38	$55,494
DIETICIAN	HSA-Grid 11	29.41	$57,506
DIETETIC STAFF/Cook/Aides	Cook1/Cook2/FSW1-S	17.96	$35,167
ADMINISTRATOR	CCERA	Scale	$56,722
HUMAN RESOURCES	Clerk	18.05	$35,295
HEALTH RECORDS	Clerk	18.05	$35,295
SWITCHBOARD	Clerk	18.05	$35,295
PAYABLES/REC/COMFORT ACC	Clerk	18.05	$35,295
VOLUNTEER COORDINATOR	CCERA	Scale	$39,256
ACCOUNTANT/MANAGER	CCERA	Scale	$43,075
SECRETARY/STOREMAN/UNIT (	Clerk	18.05	$35,295
MATERIEL MANAGEMENT (BUY	R21-12M	18.57	$36,314
DIRECTOR, ENVIRON. SERVICE	CCERA	Scale	$39,286
LAUNDRY - PERSONAL	Laundry	17.17	$33,568
LAUNDRY - DISTRIBUTION	Laundry	17.17	$33,568
HOUSEKEEPING-CLEANER/AIDE	Housekeeping	17.19	$33,606
HOUSEKEEPING SUPERVISOR	CCERA	Scale	$33,120
SECURITY	Clerk	18.05	$35,295
PHYSICAL PLANT STAFF	Maintenance	17.46	$34,145
EMPLOYEE HEALTH NURSE	BCNU-4th	24.72	$48,347
PAYROLL	Clerk	18.05	$35,295
EDUCATION & QA COORDINAT(	BCNU-4th	24.72	$48,347

Dietary Blended Rate	COOK1	COOK2	Diet Aide	Total
	$18.46	$17.60	$16.26	$16.97

0

I.C.1	I.C.2	I.C.3	E.C.	TOTAL
0.00	0.00	4.83	2.91	4.83
0.00	0.00	13.72	6.06	13.72

I.C.1	I.C.2	I.C.3	E.C.	TOTAL
0	$0	20601	13185	20601

MULTILEVEL SERVICE COSTING GUIDELINES 2000/2001
ATTACHED UNITS - NON - PROFIT FACILITIES

PROVIDER NAME: Ominaca Lodge and APC

PROVIDER NO:

TOTAL MLS BEDS:	50.5
OCCUP. RATE:	1

APPENDIX D

RESIDENTIAL FACILITY BUDGET AND SCOPE MODEL: CURRENT MLC DESIGN GUIDELINES

Residential Facility Budget and Scope Model: Current MLC Design Guidelines

Version 1 OPO

PROJECT CRITERIA		
PROJECT No.		
TOTAL BEDS (50, 75, 100, 125, 150)	50	Total Beds
NUMBER OF DOUBLE ROOMS	3	Double Rooms
PROJECT LOCATION No.	64	See Note 8
NUMBER OF STORIES	1	
COMBUSTIBLE CONSTRUCTION	Y	(Y/N)

DATES	
DATE PREPARED:	06-Mar-01
PREPARED BY:	
DATE UPDATED:	
UPDATED BY:	
DATE UPDATED:	
UPDATED BY:	

PROTOTYPICAL FUNCTIONAL PROGRAM

FUNCTIONAL PROGRAM	GFA	
A. RESIDENTIAL	2,235	m^2
B. ADMINISTRATION	236	m^2
C. SUPPORT	322	m^2
D. SERVICE	418	m^2
E. FOOD SERVICES	204	m^2
F. VERTICAL CIRCULATION		m^2
G. BALCONIES/TERRACES		m^3
H. SHARED SPACES	(277)	m^3
		m^3
TOTAL GROSS FLOOR AREA	3,138	m^2
GROSS AREA PER BED	63	m^2

PROJECT BUDGET

CATEGORY	GFA	UNIT RATE	BUDGET
PLANNING & DESIGN FEES		12.50%	$621,531
CONSTRUCTION	3,138 m^2	$1,372.51	$4,307,202
BLDG. SUPPLEMENTARY COSTS			$240,000
SITE DEVELOPMENT			$256,000
SITE SUPPLEMENTARY COSTS			$25,000
ESCALATION RESERVE (Note 4)			144,846
CONSTR. CONTINGENCY		3.00%	$144,846
PROJECT CONTINGENCY (Note 5)		5.00%	$241,410
EQUIPMENT		$10,000	$500,000
LAND			$0
GST (excluding land)		3.50%	$226,833
		TOTAL PROJECT BUDGET	$6,707,768

WILL THE NEW FACILITY HAVE THE FOLLOWING FUNCTIONS? (ENTER Y or N)

Multi-Purpose Room	Y		m^2
Laundry	N	55	m^2
Kitchen/Food Preparation	N	116	m^2
Food Storage	N	20	m^2
Staff Canteen	N	40	m^2
Staff Room	Y		m^2
Staff Lockers	Y		m^2
Battery Charging	Y		m^2
Receiving/Waste Disposal	N	11	m^2
Maintenance	N	20	m^3
Generator	N	15	m^2
TOTAL SHARED SPACE		277	m^2

IDENTIFY SUPPLEMENTARY COSTS (PROVIDE DETAILS IN NOTES BELOW)

BUILDING:	NOTE:	
POOR SUBSURFACE BEARING CAPACITY		
STEEPLY SLOPING SITE		
SUBSTRUCTURE PREMIUM		
UNDERGRND PARKING (1space/2 beds @$12,000)		
DAY CENTRE COSTS	7	$240,000
TOTAL BUILDING SUPPLEMENTARY COSTS		$240,000
SITE DEVELOPMENT:		
UNSUITABLE / UNSTABLE SOILS		
STEEPLY SLOPING SITE		
ADDNL. GRADE PARKIING (1space/2 beds @$1,000)	6	$25,000
MAJOR SERVICE RE-LOCATION		
TOTAL SITE SUPPLEMENTARY COSTS		$25,000

NOTES:

1 Location of factor of 17.5% used by choosing location 64 (equals 17.5%).

2 Total fees for new residential projects estimated at 12.5%.

3 Equipment estimated at $10,000 per bed as per guidelines that exclude laundry and equipment costs. Laundry and equipment are provided by the hospital.

4 Escalation of 3% per annum between 1999 and 2002 included in escalation reserve = 9% of n15:n18.

5 As per sheet, project contingency of 5% of cells N15:N18 used in Project contingency value.

dditional grade parking of 25 spots estimated.

centre construction costs estimated at 200 m2 at $1200/m2.

8 Based on information obtained from BCBC, the estimated location factor for Vanderhoof is currently 17.5%. Location 64 was chosen to reflect this factor.

APPENDIX E

CAPITAL PROJECT REQUEST

MINISTRY OF HEALTH
HEALTH CAPITAL ASSESSMENTS & PLANNING SYSTEM

Capital Project Request

Appendix 1

FISCAL YEAR: 2001/2002

Capital Project Request # : 0010008

HA/Agency Name:	**Northern Interior Regional Health Board**
Site Name:	**Omineca Lodge**
Site Contact:	**Michael A. Leisinger**
Location:	**Vanderhoof**
Project Name:	**Multi-level Care Facility**
Project Type:	**Major Project** **Greater than or equal to $1.5M**
Driver Type:	**Replacement**
Project Start Year:	**2001/2002**
Status:	**Submitted**
HA Priority:	**1**
MOH Cost Share %:	**100**
RHD Approval in Principle:	**YES**
Brief Description:	**Replace the 36 long term care beds at Omineca Lodge with a 50-bed multi-level care facility on the site of St.John Hospital, Vanderhoof. Renovate the existing Omineca Lodge for seniors supportive housing.**

Project Details

General

Prior Year Requested 1999

Clear Description

Construct a 50-bed multi-level care facility on the St. John Hospital site in Vanderhoof. Existing 36-bed Omineca Lodge redeveloped into seniors housing. Close 6 EC beds at St. John Hospital.

Objectives

1) Resolve safety and code issues, 2) Satisfy current multi-level care demand, and 3) Respond to current and future demographic pressure.

Other Funding

Stuart-Nechako RHD has agreed to share in the capital cost of the multi-level care facility. MoH share will be less than 100%. BC Housing or alternative procurement will be pursued for the renovation of the existing Omineca Lodge.

Dollar Range

$5 million to $9.9 million range

Detailed cost estimates using Ministry of Finance modelling are provided in the supplemental documentation.

% Maintenance/Repair

% Renovation/Upgrades

% Replacement 72

% Expansion 28

Implication

Capital Project Request # 0010008

Project Details

Implication

Consequences

The present Omineca Lodge does not meet the BC Building Code, BC Fire Code, or Adult Care Regulations. High level of community support and political interest. Deferral delays response to increasing demographic pressures.

Additional Operating Cost ($) $1,021,000

Operating Implications

The NIRHB will transfer operating $ for the existing Omineca Lodge, the 6 EC beds at the hospital, and the resident contributions. The reaminder will be required from the Ministry of Health.

Justification

Alternatives

The current facility must be replaced due to safety and care provision concerns. Building a replacement facility outside the health service area is not an option.

Building Code Mandate YES ◉ NO ○

Demographic Pressures YES ◉ NO ○

Legal Mandate YES ○ NO ◉

Project Rationale Other YES ◉ NO ○

Project Rational Comments

The present facility has BC Fire Code, BC Building Code, and Adult Care Regulation deficiencies posing documented safety concerns for staff and residents.

Environmental Issues

Identified safety issues. High level of community and political support, interest and concern.

Demographic Changes YES ◉ NO ○

Technology Changes YES ○ NO ◉

Community Resistance YES ◉ NO ○

Program Mandate Changes YES ◉ NO ○

Risks/Issues Other YES ◉ NO ○

Risks/Issues Comments

Increased service provision integration through co-location on hospital site.

Part A Submitted YES ◉ NO ○

Supporting Documentation YES ◉ NO ○

Stuart-Nechako
Regional Hospital District

P.O. Box 820
Burns Lake, B.C. V0J 1E0
Phone (250) 692-3195
Fax (250) 692-3305

June 2, 2000

Northern Interior Regional Health Board
2000 - 15th Avenue
Prince George, B.C.
V2M 1S2

also faxed 565-2640

Attention: Mr. Michael Leisinger, Regional Director - Special Projects & Evaluation

Dear Mr. Leisinger:

Thank you for attending our June Board meeting, yesterday afternoon.

I am writing, on behalf of the Hospital District Board, in support of the Regional Health Board's Major Capital Project Request to the Ministry of Health, for construction of a Multi-level care facility in Vanderhoof. The Board reviewed that Request at its meeting yesterday, and passed a motion in support of it.

In its motion of support, the Board recognizes the need for 75 Multi-level care beds to provide for expected growth in patient demand in the next 5 to 10 years. Construction of a 75 bed facility is easier for the Regional Hospital District to finance than a 50 bed facility and a 25 bed addition. However, the Board realizes that construction of a 50 bed facility will meet immediate patient needs.

Like the Regional Health Board, our Board has stated that this project is the NUMBER ONE major capital priority in our Regional Hospital District.

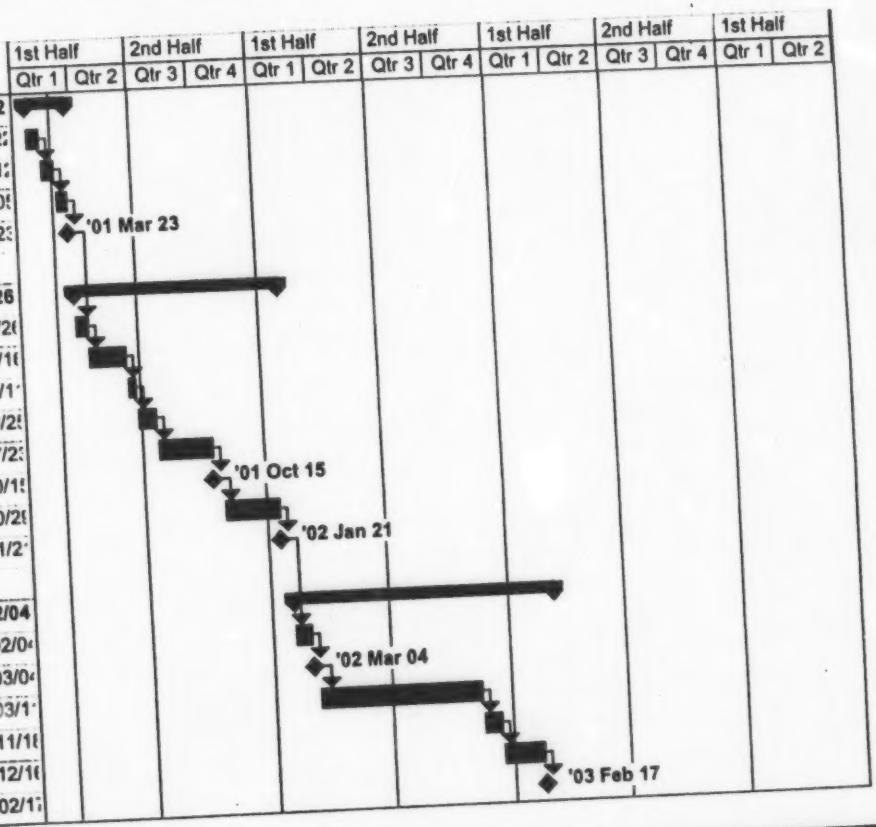
We hope that this Major Capital Project Request is received favourably by the Ministry, and if so we look forward to detailed discussion of the project scope and financing with both the Ministry and the Regional Health Board.

Please contact us again if we can support this Request in any way.

Sincerely,

Donald Jacquest, Treasurer

APPENDIX F

IMPLEMENTATION PLAN

ID	Task Name	Duration	Start
1	**Project Request Submission**	**45 days**	**Mon 01/01/22**
2	Part A Submission	15 days	Mon 01/01/2
3	Part B Submission	15 days	Mon 01/02/1
4	Ministry Review	14 days	Mon 01/03/0
5	Ministry Approval to Proceed	1 day	Fri 01/03/2
6			
7	**Design Process**	**225 days**	**Mon 01/03/26**
8	Selection of Program Consultant	3 wks	Mon 01/03/2
9	Detailed Functional Program	40 days	Mon 01/04/1
10	Functional Program Approval	10 days	Mon 01/06/1
11	Selection of Project Consultant Team	4 wks	Mon 01/06/2
12	Schematic Design	60 days	Mon 01/07/2
13	Schematic Approval	10 days	Mon 01/10/1
14	Working Drawings	60 days	Mon 01/10/2
15	Working Drawings Approval	10 days	Mon 02/01/2
16			
17	**Construction Phase**	**290 days**	**Mon 02/02/04**
18	Tender Issued	20 days	Mon 02/02/0
19	Tender Award	5 days	Mon 02/03/0
20	Construction Period	180 days	Mon 02/03/1
21	Substantial Performance	20 days	Mon 02/11/1
22	Commissioning	9 wks	Mon 02/12/1
23	Occupancy	20 days	Mon 03/02/1